Proposal prepared for:

Jefferson Parish Government

SOQ No. 22-037
Quote Date: August 18, 2022
Effective Date: January 1, 2023

Group Medicare Advantage Plan with a Nationwide Provider Network for all Medicare Eligible Retirees and Dependents

Submitted by: Erin Dey | Senior Account Executive | 504-343-0158 | edey@humana.com

Humana Offering Company Statement

The benefits outlined in this proposal are offered by the following companies, hereafter referred to collectively as "Humana:"

- Fully insured Medicare Advantage prescription drug (MAPD) PPO plans in Louisiana are insured by Humana Insurance Company
- Fully insured MAPD HMO plans in Louisiana are insured by Humana Health Benefit Plan of Louisiana, Inc.

Humana Inc. is the ultimate parent company and not an offering company. Humana Inc. holds no insurance licenses or health plan licenses.

Humana is a Medicare Advantage organization and a stand-alone prescription drug plan with a Medicare contract. Humana Medicare Advantage Employer Plans are governed by federal law and guidance published by the Centers for Medicare & Medicaid Services (CMS). Humana Medicare Advantage Employer Group plans comply with all federal regulatory requirements. Any new regulatory requirements, or changes to existing regulations, are implemented in accordance with both federal and applicable state laws and guidelines. In addition, Humana is fully compliant with the HIPAA Privacy Regulations that took effect April 14, 2003. Effective September 23, 2013, updates were made to portions of the original 2003 law which included the following federal legislation: 45 CFR Parts 160 and 164 of the HIPAA, HITECH, Privacy and Confidentiality Act of 2013. Notwithstanding any provisions of an agreement with the Group, Humana will follow federal regulatory and CMS requirements.

Humana has provided information and responses that are consistent with current internal policies and procedures; however, clients will receive the newest and most innovative solutions that Humana has to offer at the time of implementation.

Please be aware that Humana's responses include information that we consider proprietary and confidential. Humana is pleased to provide this information to assist in serving Jefferson Parish Government and simply asks that it be treated as confidential. Jefferson Parish Government's acceptance of this information is considered an agreement to these conditions.

Humana

August 18, 2022

Shanna Folse, Buyer
Jefferson Parish Government
Purchasing Department
200 Derbigny Street, Suite 4400
Gretna, Louisiana 70053

Dear Ms. Folse:

We have appreciated our longstanding (17 years) relationship providing a Medicare Advantage offering to Jefferson Parish retirees and appreciate the opportunity to respond to your Group Medicare Advantage request for proposal, SOQ 22-037. This proposal contains detailed, cost-effective healthcare solutions that we believe continue to offer Jefferson Parish the greatest opportunity to lower your healthcare costs and achieve your health and wellness goals. As part of our integrated care strategy, we focus on enhanced clinical capabilities, actionable data and analysis, and personalized service to enable the best possible experience and health outcomes for our consumers.

Over the years we have managed your Medicare eligible retirees, we have been able to control cost, manage member conditions and close gaps in care as well as provided other benefits and services that helped your retirees thrive. The members of Jefferson Parish's Humana plan provided a Net Promoter Score in 2021 of 72.31. Anything over 70 is considered world class customer service.

Erin Dey
Group Medicare, Senior Account Executive
4 Oakley Drive
Destrehan, Louisiana 70047
C 504-343-0158
E edey@humana.com

Humana Louisiana Contractor ID#
V31004171601

Humana's Medicare Advantage PPO plan will give Jefferson Parish's members the freedom to visit any doctor, specialist, or hospital that accepts Medicare while also providing richer benefits and discounts for visiting providers in our industry-leading national PPO network. Plus this plan includes our fully integrated prescription drug coverage, which allows Jefferson Parish's retirees to access Humana's broad national pharmacy network, as well as home delivery services to help curb pharmaceutical costs and promote stronger prescription adherence.

Humana's PDPs, whether integrated with our Medicare Advantage plans or not, cover more Medicare beneficiaries than any other carrier. Our PDP service areas cover the entire United States and Puerto Rico and use formularies that both meet the Center for Medicare & Medicaid Services' (CMS) standards and are

designed to be attractive to a wide range of members. Our network currently has over 63,000 retail pharmacies, including every major national and regional chain, as well as thousands of popular independent local pharmacies in every state, giving most members immediate or reasonable access to multiple pharmacy locations.

We have a synchronized suite of health management programs designed to address the entire spectrum of health needs.

Humana's goal is to provide superior service and to continue our long-term partnership with Jefferson Parish and your retirees. Creating that mutual trust and effective working relationship starts with excellent service resolving day-to-day issues. Humana excels in creating partnerships with our group clients to provide exceptional account management support and customer service.

Thank you again for considering Humana's Group PPO MAPD proposal. In addition to supplying rates for a national PPO, we are also enclosing rates for the current HMO with a PPO wrap for those who reside outside of the HMO service area for your consideration. Please do not hesitate to contact me via telephone at 504-343-0158 or by email at edey@humana.com if you have any questions or need clarification regarding any aspect of our proposal.

Sincerely,

Erin Dey
Senior Account Executive

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EXECUTIVE SUMMARY

Executive Summary

Personalized support that understands you, your employees and your retirees

Personalization

We work hand-in-hand with you to ensure your plan's individual success

Ease

Feel confident knowing you have the exact help you need at your fingertips

Care

Strong relationships and understanding ensure you get the support you deserve

When it comes to healthcare, we all have the same ultimate expectations. We want to make sure everyone has access to the resources and support they need to be their healthiest, whenever and wherever they need it. This means helping members be their healthiest and helping plan sponsors save time and money.

Going above and beyond expectations is what we do best. Leaning on our extensive experience in healthcare, we provide dedicated account management for plan sponsors, and value-added, whole-person care that's focused on doing more for improved healthcare experiences. At Humana, we believe in an integrated care delivery model that puts people's health at the center. We utilize the transformative power of technology to improve processes so providers can spend more quality time with patients. We're advocates treating the entire individual and not just their currently known issues. Most importantly, we empower healthcare providers in ways that help to ensure the best outcomes possible.

Expect More from Humana

Humana provides ***more than health insurance***–we deliver personalized, simplified ***human care***. It means replacing the traditional notions of health insurance and seeing people beyond their medical condition. It's our strategy for delivering personalized care, alleviating pain points, and driving positive change within the healthcare industry. In other words, **human care is not only *how* we're different, but *why* we're different**.

#1 in Health Insurance Customer Service in 2020 from Newsweek

Humana recently received some significant recognition in the marketplace from both our clients and the media. We have achieved a **+79 Net Promoter Score (NPS)** for Group Medicare Clients, which is considered best-in-class and have been awarded #1 in customer service by Newsweek among all health insurance companies for the second year in a row.

#1 among health insurers in Forrester's 2021 US CX Index™ Survey

Humana Medicare Advantage

Our Group Medicare Advantage PPO plans give members the freedom to visit any doctor or hospital that accepts Medicare. Humana has a national presence with Group Medicare members in every state in the country.

Our quote for Jefferson Parish includes a passive PPO plan design, giving your retirees the same benefits for in-network and out-of-network services. Members will be able to use their benefits the same way when they travel anywhere in the United States as when they're at home. And for members who want or need to use out-of-network providers, they'll find they will nearly always be able to get such care without difficulty, because Humana makes it easy for providers to get paid quickly and fairly and to maintain their patient relationships.

The current HMO offering includes a robust provider network and no referrals are required to see a specialist. The HMO plan can continue to be a great option for those residing in the service area, if you would like to consider this offering.

We understand that the needs and challenges your retirees face deserve more than a one-size-fits-all approach. Our Medicare plans are custom made to meet those needs.

Virtual Visits

As we all manage through the COVID-19 pandemic, access to telemedicine is an invaluable service to provide to your retirees. By avoiding costly trips to the emergency room, Humana members are able to safely get the medical answers they need.

Behavioral health services are also provided virtually so members can visit board-certified psychiatrists and psychologists to get non-emergency care for depression, trauma, loss, stress, or anxiety. Members can typically schedule private appointments with a provider sooner than the average in-person visit, and see the same doctor for each online session.

Through 35 years of offering Medicare Advantage we know making critical investments in programs, services and technologies is key to a successful Medicare Advantage strategy to reduce costs and improve quality and outcomes that will make Jefferson Parish's Medicare Advantage plan immediately successful, and provide sustainable, long-term value.

Personalization

Comprehensive clinical programs and chronic condition management

Humana offers a comprehensive suite of clinical programs and services to provide education and address member needs at all points on the health and well-being spectrum – helping members stay well when they are healthy and navigate the healthcare system when they are ill or injured. This promotes a healthier population, helps control cost, and delivers better experiences for both members and plan sponsors.

Our care structure considers the whole member - addressing physical, behavioral and social conditions. We deliver fully connected care management solutions with proactive identifications and timely interventions, to ensure members receive appropriate care at all stages of health.

We have also invested in technology and tools that effectively match the right members with the right clinical interventions, at the right time. All our clinicians work on the same state-of-the-art platform, which provides real-time, actionable information. This knowledge enables clinicians to engage members in order to optimize their well-being, reduce costs, and improve outcomes.

In addition, Humana offers utilization and case management tools, as well as a wide array of chronic condition management programs to provide tailored support for members and help reduce their costs. Members are generally managed by a single clinician, even if they have multiple chronic conditions. Every Humana member is screened for high acuity chronic condition management program participation using advanced proprietary algorithms. We identify participants through a variety of methods, including medical and pharmacy claims review, personal nurses working with moderate acuity members, case managers' referrals, providers' recommendations, and self-referral.

While there are standard program components for each chronic condition management program, Humana tailors the coaching and education for each program to each member's needs.

CenterWell™

CenterWell Senior Primary Care, a wholly-owned subsidiary of Humana, is our newest primary care medical group practice. CenterWell has a strong emphasis on senior-focused primary care for members of Medicare Advantage health plans and is committed to providing personalized, high-quality primary care combined with an excellent patient experience. Humana wants to provide access where our members want to receive care. Communities are in need of senior-focused primary care, and we believe that providing local access to full service primary care, pharmacy, nutrition, behavioral health, wellness support, social work and other services will help senior spend less time in the hospital and other institutional settings. In addition, CenterWell is payer-agnostic, so our heal care deliver services reach more people – including non-Humana plan members. CenterWell has seven Louisiana locations:

Hammond • Slidell • Denham Springs • Bossier City • Lafayette • Shreveport • Covington

Personalization

Holistic Wellness

Health and well-being aren't destinations, but part of a lifelong journey.

Go365 by Humana™
An innovative wellness solution that rewards participants for making healthy choices. Every member, no matter their level of health, has the ability to earn rewards.

SilverSneakers®
The nation's leading exercise and social support program for seniors is available to Jefferson Parish's retirees. At no additional cost, they will have access to:

- 15,000+ fitness locations
- Fitness classes designed for seniors
- Online workouts
- Heathy living discounts
- A fitness app designed for seniors

Virtual visits powered by MDLIVE®
We partner with MDLIVE to offer 24/7 access to convenient virtual telehealth

Humana Home Care Solutions

Humana's Home Care Solutions assist our members at every phase of their healthcare journey: From emergent in-home care, to primary care visits in the home, to skilled nursing for chronic and critical needs from Kindred at Home. It is our goal that your members have the very best patient experience. We want members to sustain independence and provide the best outcomes in their home while managing overall healthcare costs. We believe the home is the next frontier in high touch, value-based care for our members.

Kindred at Home

Humana's investment in Kindred at Home, makes us the country's largest provider of home healthcare services. Kindred at Home provides home health, hospice and personal care, and those services and providers are now fully integrated into Humana's home health and clinical expertise as part of our value-based home health service.

There are 15 Kindred at Home locations in Louisiana.

Home Care solutions for every stage of health

Preventative care and coordination	Acute care	Advanced illness
• Care management • In-home assessments • Primary care	• Home health • ER at home • Hospital at home • SNF at home	• Palliative • Hospice

Ease

Account Management

Jefferson Parish will continue to have a designated Group Medicare Account team with the experience needed to ensure the plan's continued success. This teams will smoothly transition your retirees to the PPO plan. They have the expertise to make the process seamless through effective communication with Jefferson Parish's staff and your retirees.

The Humana team will provide timely and accurate reporting on the PPO plan and provide plan recommendations based on the best practices of other similar employers as well as utilization trends for Jefferson Parish's retirees.

Jefferson Parish will continue your relationship with our experienced Group Medicare Account Team:

- ***Erin Dey***, Senior Account Management Professional
- ***Maisie Mitchell***, Account Installation Manager
- ***Christah Sykes***, Communications Consultant
- ***Courtney Bell***, Account Concierge Specialist
- ***Annie Eckert,*** Enrollment Analyst

Erin Dey, has almost 18 years of experience at Humana managing Medicare Advantage plans.

Reporting

Humana's PlanCompass will be provided annually and consists of an executive summary that provides a synopsis of member composition, health engagement activities, utilization patterns and clinical cost drivers – as well as other content areas such as member profiles, health engagement, medical and pharmacy value.

Jefferson Parish will also have access to Humana's new ePlanCompass tool which launched in 2021. This sophisticated online reporting and analytic tool will provide reporting capabilities for you and your consultant partners with pre-built templates and easy-to-understand report builders.

Humana's Custom Care Customer Service

Customer service is an integral part of Humana's consumer engagement efforts. From Humana's operational procedures to the recruitment and training of our Customer Care specialists, Humana is organized around a client-focused approach. As a consumer-centric company, we strive for proactive, personalized service through a key metric we brand internally as the Perfect Experience. This multifaceted approach to customer service encompasses:

- A focus on human capital, which begins with selecting the best talent and preparing and engaging those associates through extensive service orientation, practice, and ongoing training
- A commitment to developing a strong "outside in" perspective of every customer interaction, as well as the processes underlying those interactions
- A comprehensive call quality program that utilizes multiple methodologies to evaluate both associate performance and member satisfaction

Humana takes a whole-person approach to supporting your retirees through every aspect of their health

Dedicated Group Medicare Customer Service

Humana has undergone a fundamental transformation in how we approach customer service. The Custom Care philosophy centers around making each member feel connected to Humana and helping them achieve their best health. This changes a standard call center atmosphere into an environment filled with personalized advocacy representatives.

We start with a focus on the unmet needs that matter most to our members, and then align our actions and behaviors to go above and beyond to meet those needs. Ultimately, we deliver a more human experience.

We begin engaging with your retirees by making welcome calls to each individual member. The purpose of the call is to help bridge the transition for pensioners moving to Humana. During this call associates will welcome each member to Humana while also outlining the value of their benefits and the services available.

Through this advocacy model, each associate is empowered to deliver a compassionate, informed and proactive experience for our members. Our Group Medicare associates are encouraged to take responsibility for owning the end-to-end member transactional experience, including making outbound calls when necessary or scheduling a time to follow up with members when needed.

As a result, Humana recently received some significant recognition in the marketplace from both our clients and the media. We have achieved a **+79 Net Promoter Score (NPS) for Group Medicare Clients,** which is considered best-in-class and have been awarded **#1 in customer service by Newsweek** among all health insurance companies for two years in a row.

Care

Humana in the Community

Bringing Humana personalized healthcare and customer service directly to our members is a reflection of our belief in human care. Where we have significant populations of Medicare Advantage members, we have storefront **Humana Neighborhood Centers** designed to help retirees live their healthiest, happiest lives. The Humana Neighborhood Centers work to address whole-person care, increase access to preventive care, address member questions and improve health outcomes. **We are the only national MA carrier that supports stand-alone locations specifically for member support.**

Nationally, Humana has 49 center locations including five locations in Louisiana:
Baton Rouge, Lafayette, Lake Charles, Metairie and Shreveport

Additionally, for Humana's MA members, we have launched a virtual experience where retirees can easily and safely participate in health and wellness activities online. This virtual neighborhood center (HumanaNeighborhoodCenter.com) offers online health and informational programs.

Louisiana's Bold Goal

Louisiana is home to two Bold Goal communities, Baton Rouge and New Orleans, and we serve members statewide, including Medicare Advantage, and Commercial members.

Humana's Bold Goal is to improve the health of the people and communities we serve by making it easy for people to achieve their best health. We address whole-person health, and particularly Health-Related Social Needs, by co-creating solutions that seamlessly integrate clinical and social aspects of care. Through our Bold Goal, we are collaborating with nonprofit organizations, businesses, government leaders, and healthcare professionals.

Humana collaborates with the Greater New Orleans Region, which includes Jefferson Parish and local community-based organizations to address social determinants of health (SDOH) and develop direct interventions to support the most vulnerable member populations.

As part of the Greater New Orleans Bold Goal, including Jefferson Parish, we are using education and awareness to help improve health outcomes of the citizens in our community

- *Humana is focused on creating solutions that address disparities for more equitable care and health outcome: With more than $16 million in community investments since 2019, and investments in March of Dimes partnership to impact moms and babies.*
- *As a top priority to provide access to behavioral health services in rural Louisiana, Humana continues to lead conversations with partner organizations, like National Alliance of Mental Illness (NAMI), to address the stigma associated with needing and seeking services.*

Care for Seniors

Value-based care

Our long-term network growth strategy emphasizes value-based care. Value-based care offers providers financial rewards for improvements in outcomes, quality and cost, which benefits retirees more than a traditional fee-for-service model. Humana's support of value-based care means healthcare professionals have access to sophisticated tools, capabilities and services designed to make population health management easier. It also offers alternative care options including virtual visits and home-based appointments giving members the option to receive care where and how they are most comfortable.

Value-based care leads to better health outcomes for members over traditional Medicare. Some examples include:

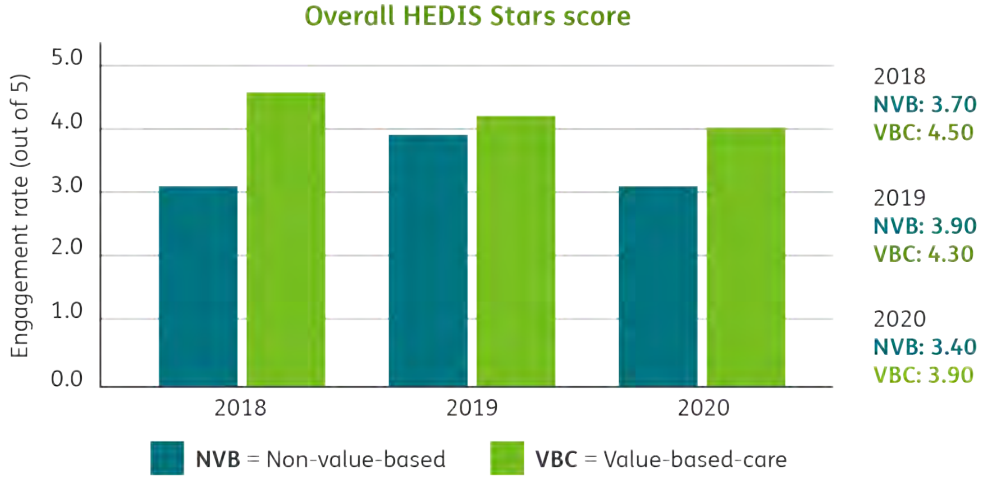
- **14.6% lower ER visits**
- **27% lower hospital admissions**
- **20% lower reduction in healthcare costs**
- **Improved blood pressure and diabetes control**

STARS

Our Group Medicare Advantage PPO plans have earned 4-Star or higher quality ratings from the Centers for Medicare & Medicaid Services (CMS) for 2020 and 2021. Jefferson Parish's current HMO plan is a 5-Star plan. These ratings are an affirmation of both the ordinary and extraordinary effort our thousands of associates and provider network partners make to provide quality benefit and care experiences for our members.

Approximately **99% of Group MA members** are in a 4-star or higher contract and **92% of all Humana members** are in a 4-Star or

Having 92% of all Humana MA members in a 4-Star or higher contract is the highest percentage amongst our largest competitors.



Ratings show better patient engagement for those in value-based practices

Care

Integrated pharmacy benefit management services for all plans

Humana Pharmacy Solutions® is a complete pharmacy benefit manager (PBM). Currently we are one of the largest PBMs in the country, managing approximately $18 billion in drug spend and processing more than 300 million prescriptions each year. Real-time pharmacy and medical benefit data integration means that all Humana Clinical and Care Management teams have access to a full picture of the member, and they can close gaps in care, address safety concerns, and use predictive modeling to anticipate member needs.

Members can also order mail-delivery prescriptions through CenterWell Pharmacy™ (formerly Humana Pharmacy®) and order refills by phone, fax, mail, our through our award-winning **HumanaPharmacy.com** website and Humana Pharmacy mobile app. Our professionals review all prescription orders and pharmacists inspect each one to provide accuracy.

CenterWell Specialty Pharmacy™ (formerly Humana Specialty Pharmacy®) allows us to provide high-quality, lower-cost specialty medications to your specialty patients. Our nurses and pharmacists work closely with the Parish's members and their doctors to help manage specialty medication therapy effectively. Specialty nurses may also refer members to other Humana programs and services as appropriate. Our professionals review all prescription orders and pharmacists inspect each one to provide accuracy.

Real-time reporting also positively impacts risk adjustments, Stars reporting and other quality measures.

By integrating pharmacy and medical with an MAPD plan from Humana, you are giving your retirees a simpler, more member-friendly experience. They will benefit from having just one company, with one phone number to call, one ID card and one Explanation of Benefits. MAPD plans also provide a simpler administrative and service experience for plan sponsors through a single, combined eligibility process, lower administrative costs, and integrated plan reporting and consultation.

CenterWell Pharmacy achieved the No. 1 ranking for Mail Order Pharmacy customer satisfaction by J.D. Power for the fourth consecutive year in their 2021 U.S. Pharmacy Study.

Specialty Pharmacy PATIENT CHOICE AWARD PBM/Payer Specialty Pharmacy

Our excellent customer service is part of the reason CenterWell Specialty Pharmacy is a three-time winner (2018, 2019 and 2020) of the JD Power Zitter Specialty Pharmacy Patient Choice Award in the PBM/Payer category.

In conclusion

Thank you for considering Humana

Throughout our proposal, we have highlighted the strengths of our clinical, operational, and account management capabilities for our Group Medicare plans. We are confident Humana can continue to provide an MA strategy that would provide the greatest value and facilitate the highest quality care to your Medicare-eligible retirees and their dependents.

We believe the most effective, affordable and sustainable value-based healthcare solutions require critical investments and dedication to continual improvement. Through innovative products and services, Humana guides members in taking control of their health. The result is a better experience and lower healthcare costs for both members and employers.

We look forward to discussing our proposal and capabilities with you and appreciate your continued interest in Humana.

MINIMUM QUALIFICATIONS

Minimum Qualifications

1. **Proposer must be licensed in Louisiana. Please provide copies of all licensing credentials.**

   Confirmed. Humana's two offering companies below are licensed to conduct business in the state of Louisiana:
   - Humana Insurance Company
   - Humana Health Benefit Plan of Louisiana, Inc.

   Please refer to Attachment A for copies of all licensing credentials.

2. **Proposer must have at least five (5) years of experience in providing the type of plans and services requested in this SOQ.**

   Confirmed. Humana Inc., headquartered in Louisville, Kentucky, is a leading healthcare company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Medicare is a significant part of Humana's business and a major contributor to our success. We offered our first private Medicare plans in 1985 and our first Medicare plans for employers in 1990. Since then, we have continuously provided the stability, depth of expertise, infrastructure, and sophistication to meet all our Medicare members' needs.

   In terms of membership, Humana has always been one of the largest Medicare carriers. In 2005, we had approximately 560,000 Medicare members. With the start of PDPs and the full-fledged introduction of private fee-for-service (PFFS) and Regional PPO plans in 2006, our membership grew to more than 3.5 million members. Our total Medicare membership now stands at over 8.7 million, making us one of the two largest Medicare and PDP carriers.

   To serve the large size and geographic scope of Humana's Medicare Advantage program, we have built a large infrastructure to support our Medicare and other senior products. As of today, our Senior Products Division has nearly 14,000 associates engaged in supporting every aspect of Medicare plan operations: product development, sales, compliance, enrollment, claims processing, and member services. Our Humana office in Metairie's Galleria building has 718 employees and 789 total employees in Louisiana, supporting local and state economies.

3. **Proposer must offer the type of plans and services as described in this SOQ to at least two (2) similar employer groups or municipalities with similar total members as Jefferson Parish Government, and provide as references.**

   Confirmed.

   1. **City of Newport News**
      Brian Sypolt
      sypoltbj@nnva.gov
      757-926-8499

2. **Gwinnett County Government**
   Karissa Ogburn
   Karissa.ogburn@gwinnettcounty.com
   770-822-7912

3. **Lafourche Parish School Board**
   Chastity Himel
   chimel@mylpsd.com
   985-435-4658

RESPONSE TO SCOPE OF SERVICES

Response to Scope of Services

General Services
Mail all plan related materials to all covered retirees to be received prior to commencement of open enrollment meetings on an annual basis. Materials will include plan summary, all-inclusive network provider list/booklet, prescription drug coverage information, material describing ancillary coverage, such as dental, vision, etc.

Confirmed. Please refer to Attachment B for a copy of Jefferson Parish's current enrollment materials. Each enrollment kit is specific to the local market in which the member resides.

Through Humana's decades of Medicare experience, we have developed a communication plan attuned to the specific needs of retirees. For Jefferson Parish, we can offer a comprehensive campaign with preliminary mailings that outline some of our available services. We supply all pre-enrollment and enrollment materials in print. Groups may also opt to upload PDF files of communication materials to their website.

Our Group Medicare member communication strategy consists of various components, which may include the following, based on Jefferson Parish's needs:

- **Pre-enrollment Kits**: mailed to new groups or new members of existing groups prior to the commencement of open enrollment
- **Post-Enrollment Communications:** include extra services guide, retention initiatives and other components as needed
- **Custom Communications Pieces:** letters, postcards, etc.

  Humana has prepared a custom recorded presentation that Jefferson Parish posts on their website:
  https://www.brainshark.com/humana/vu?pi=zJEzb2axmzWnemz0

- **Customer Care:** dedicated Customer Care center

In the process of creating the communication strategy, Humana also strives to remain CMS compliant. To keep it simple, we have assigned a dedicated communications consultant, Christah Sykes, to manage all of Jefferson Parish's communications needs. Christah provides information on timelines, processes, etc., and consults with Jefferson Parish throughout the overall communications strategy.

Initial member communications
We mail enrollment kits as groups join Humana or renewal kits if there are benefit changes or new plan offerings as groups renew with Humana. We have local market representatives designated to support Jefferson Parish and they have kits available to share with retirees interested in joining the Humana plan and can review the materials with retirees on a one-on-one basis. Our enrollment kit typically includes:

- Welcome letter to retirees
- Enrollment application and return envelope or Enrollment Information Guide
- Guidebook
- Medical summary of benefits, including list of ancillary services
- Pharmacy summary of benefits
- Pharmacy Abbreviated Drug Guide

- CenterWell Pharmacy flyer (pharmacy mail-order service)
- Go365 flyer (Humana's health and wellness program)
- Member to provider flyer (passive/transitional PPO plans)
- Seminar invitation (if applicable)

Provider directories are available as hard copies and as printable PDFs online. To ensure members have the most current provider listing, Humana informs members within the enrollment materials with ways they can request printed provider directories including calling our toll-free customer service line or online at **Humana.com**. A dedicated interactive voice response (IVR) line is also setup for retirees to request a directory 24 hours a day, seven days a week. We also mail members a postcard annually advising how to request a printed directory be mailed to them.

Anyone can also access provider directories online at **Humana.com** at any time or through our mobile application. Using our online provider search tool, Physician Finder Plus, prospective and active members can find in-network providers by name, specialty, and/or location, as well as those who will provide house calls or conduct virtual visits. This information is updated nightly.

We also can coordinate and host enrollment seminars as requested by Jefferson Parish. Meetings are conducted by licensed professionals and we can include meeting invitations in the informational kits. If we collect member email addresses, Humana will also coordinate an email reminder for meetings. Mail dates are based on the enrollment period, effective dates, and the client review process.

Additional Member Communications
Humana makes the following communication materials available to members on an ongoing basis throughout the plan year:

- Clinical guidance (case and disease management)
- Phone calls, surveys, letters, booklets and other mailings for health education seminars and workshops
- SmartSummary® statement
- Provider Directories
- Prescription Drug Guides
- Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) (annually)
- EOC for upcoming year

In addition, we send clinical communications to members to encourage them to practice preventive care or to help manage a health condition. These communications include telephone and mail reminders for preventive screenings such as mammography, colorectal cancer, and osteoporosis. Condition-specific reminders are sent to members with diabetes, cardiovascular disease, and other conditions.

SmartSummary
Each month, members also receive a statement of their personal health benefits which provides a full picture of the member's use of healthcare services and associated costs, such as doctor's visits, lab work, therapies, hospitalizations, medication, copayments, and deductibles. By showing retirees how exactly they're using their benefits, we better engage them in their spending and help them to decide about how best to utilize their benefits going forward.

Will comply with all applicable Federal, State and Local laws, rules and regulations. These laws, rules and regulations will be deemed to be included in the contract the same as though herein written in full.

Confirmed.

The healthcare provider must mail subscriber and dependent ID cards annually prior to the first of each year after open enrollment.

Confirmed. As your chosen carrier, after Humana receives a clean enrollment file (with no enrollment pend errors), we mail Medicare Advantage ID cards for new contracts, future plan years, and newly eligible members within eight days. Members receive these ID cards 10 to 14 business days after we receive the enrollment data.

Humana's best practice is to issue new cards to members every three years, with the capability to request new cards annually per Jefferson Parish's direction.

Members always have access to ID cards by logging in to MyHumana where they may print a PDF of their ID card. Through our mobile app, members have access to medical and pharmacy ID cards and can send their ID card to a provider and save their card as an image to their photo gallery.

Provide annual open enrollment support by providing a speaker at each employee and retiree meeting upon request. Provide representatives to meet with retirees individually upon request for possible enrollment when the retiree reaches age 65.

Confirmed. During enrollment, an experienced, licensed, certified team of representatives conducts seminars upon request. This team of professionals receives an in-depth orientation to cover Jefferson Parish's entire program including eligibility and benefits and any additional areas of focus determined to be helpful in the enrollment process.

Humana has two representatives assigned to the Jefferson Parish account, Nidia Martinez and Scott Rauch. When a retiree is interested in joining the Humana plan, Nidia or Scott will schedule an appointment with the retiree and review the plan details. Nidia and Scott assist the retiree with completing the application and ensure the application is sent timely to both Humana and the Jefferson Parish retiree office.

Humana also offers Bringing Humana to You (BH2U) meetings to our clients. These are planned throughout the year to bring retirees to either Humana neighborhood Centers, SilverSneakers facilities, or other client or community facilities to educate members on their benefits, clinical and health and wellness programs, and other condition management topics. It's a great way for retirees to come out and meet with Humana to ask questions and better understand their benefit, ask claims questions, and learn more about plan services.

During these meetings, we:

- Promote SilverSneakers
- Educate members about our Humana Care Management programs
- Share other resources available

These meetings can coincide with a retiree association, as Humana has supported in the past with the Jefferson Parish retiree association, or we also offer BH2Us as stand-alone meetings.

Professional Services
Provide a network of physicians, hospitals and ancillary medical providers. Maintain a thorough, well documented credentialing procedure, and conduct an ongoing quality assurance program under the purview of a peer review committee.

Humana is well-positioned to offer a Medicare Advantage PPO product to Jefferson Parish that covers your Medicare-eligible retirees with one of the largest Medicare Advantage networks with 900,000 providers in all 50 states, Puerto Rico, and Washington D.C. through our broad PPO network. These plan designs allow us to take advantage of our Medicare Stars rating to provide competitive rates for retirees, which enhances member activation and engagement in wellness and chronic condition management programs, care management compliance and cost effectiveness, and our ability to more effectively manage medical cost trends.

We also cover individuals living outside our Medicare Advantage PPO service areas under our Medicare Advantage PPO Expansion Waiver with CMS. This waiver permits us to provide traditional or passive Medicare Advantage PPO benefits to these members and results in 100% of all members being provided a single, uniform, national plan of benefits.

We are constantly building better performing networks, by analyzing provider performance using an episode-of-care methodology that analyzes inpatient, outpatient, ambulatory and pharmacy claims data, adjusting it for differences in patient severity and geographic variation. Using this and other techniques, Humana is improving network performance in a number of ways, including:

- Engaging providers that are performing less favorable than their peers to improve their performance against key measures.
- Challenging average performing providers with opportunities to improve based on best practices demonstrated by highest performing peers.
- Providing high performers with additional opportunities and incentives to excel.

We ensure adequate provider access by contracting with a minimum of 65% of available providers required by CMS (across key specialty categories) in all network service area counties. Key providers include hospitals and other medical facilities (such as ambulatory surgery centers and skilled nursing and rehabilitation facilities), primary care physicians (PCP), high-volume specialists (i.e., cardiologists, ophthalmologists, and orthopedic surgeons), and ancillary care providers (i.e., diagnostic laboratories, imaging centers, and home health providers). We assess and monitor network adequacy, scope and performance, CAHPS scores, and member complaints using a variety of industry-accepted tools, such as Quest Analytics, as well as our own proprietary programs.

Credentialing Procedure
Humana's approach to recruiting and credentialing providers and pharmacies includes imperatives to control costs while improving outcomes. This approach drives our strategy to work and contract with providers to develop more efficient and cost-effective networks for both our HMO and PPO products.

Providers applying for participation with Humana must submit a credentialing application and meet credentialing criteria prior to approval. Once initially credentialed, providers are recredentialed every three years.

Each Humana region manages its own contracting process and activity, to ensure responsiveness to the competitive, economic, political, and other circumstances unique to each market. The following outlines the general steps used by Humana's provider contracting staff, although the order and nature of each activity can vary:

- Providers are identified through member/group nominations, provider requests to join, hospital rosters, and community searches.
- For hospitals, physician practices, solo practices, and other facility providers, a provider contractor contacts each provider and discusses the Medicare and commercial product line opportunities for participating with Humana.
- Solo and small physician practices have the ability to request participation through an online tool via Humana's website. The request is then submitted to the market office to follow up directly with physician practice.
- Humana and provider representatives may or may not reach mutually-agreeable contract terms for participation in one or more of Humana's provider networks.
- Upon reaching agreement, each provider must successfully complete Humana's credentialing process. This process may take 45 to 90 days due to the time involved in verifying provider license, certification, malpractice, liability insurance and other information.
- Once credentialing is approved, the provider contractor submits the signed agreement and other necessary information to load the provider into Humana's provider directory, claims payment, and other systems.
- The next step is for the provider contractor or a provider relations representative to begin the process of educating the provider and its staff regarding Humana's policies and procedures, claims submission process, benefit plans, and so forth. Each provider receives a welcome letter with the effective date with Humana, a copy of their signed agreement, and educational materials.
- When providers render services to a patient, they submit a claim to Humana (increasingly electronically but occasionally on paper), and Humana processes the claim.
- If the providers have any questions, they contact Humana through a secure provider portal at **Humana.com** or by phone at 1-800-4-HUMANA.
- When a provider changes contact information (phone number, address, etc.), they submit the changes to Humana in writing via letter or email, and Humana then makes the changes to its systems.
- A provider wishing to terminate its contract must first submit a termination letter to Humana that includes the reason for and date of termination.

Credentialing Criteria

The decision to credential or recredential providers is based on the following criteria:

- Holds a current valid state professional license
- Holds a current federal DEA certificate and/or a CDS certificate, if applicable to profession
- Holds current PLI
- Has completed appropriate education and training for applied specialty
- Demonstrates appropriate history of employment and clinical practice
- Holds current clinical privileges in good standing at a participating facility, if applicable to profession
- Has acceptable liability claims history

- Represents sanction-free status by federal, state, and local authorities
- Demonstrates lack of physical or mental impairment, including impairments due to chemical dependency that may impair the practitioner's ability to practice or may pose a risk of harm to patients
- Demonstrates acceptable office survey results, if applicable

Hospitals

Humana generally enters into full service, direct contracts with network hospitals in order to facilitate member convenience and access. In addition, we utilize specific service agreements with hospitals for organ transplant coverage and to provide coverage at a hospital in an area where our primary network facility does not offer a certain medical specialty service.

Behavioral Providers

We are continuously expanding our extensive behavioral health network through various development initiatives, including provider recruitment via member referral and direct outreach by our provider contracting team. Following recruitment, practitioners and facilities must complete our credentialing and contracting processes. If a member is in immediate need of care, we will initiate a single case agreement with a qualified local provider and authorize services until the full contracting process can be completed.

Pharmacy Credentialing

At point of contracting, all pharmacies are required to provide the following for credentialing purposes:

- Copy of active facility state license
- Copy of active Drug Enforcement Agency (DEA) registration or state controlled substance certificate (as applicable)
- Proof of professional liability insurance coverage that meets the minimum requirement of $1,000,000 per claim and aggregate
- Pharmacist in charge must complete a credentialing form and provide a copy of their current state pharmacist license

Once contracted, all pharmacies are required to comply with our recredentialing process which includes providing current copies of the items above.

Quality Assurance Program

Humana manages the quality and performance of our providers in-house both at a corporate level and local level. Each local health plan or region operates a Quality Management Committee (QMC), which meets at least quarterly to integrate quality improvement activities plan wide. Each market's QMC monitors progress toward strategic goals and provides positive opportunities for continuous quality improvement.

Programs incorporate an ongoing educational focus geared toward improving the quality of health services delivered by network providers. The QMC is interdisciplinary and is supported by plan staff associates from departments such as medical management, accreditation, risk management, service, and compliance.

The QMC has various subcommittees that reflect quality management activities, utilization management activities, and service activities. Network and market physicians participate on the quality management and utilization management subcommittees. The QMC is responsible for reviewing and evaluating aspects of preventive and clinical care at the market level.

The QMC is empowered to develop appropriate corrective actions and quality improvement interventions. A Humana medical director or a physician designee chairs the QMC, which includes physician members who are actively practicing in the provider network. Members of the QMC may include representatives from:

- Medical director or physician designee (chair)
- Quality operations compliance and accreditation
- Clinical programs
- Practicing network physicians
- Account Management Team representative
- Additional representatives as appropriate

Corporate Quality Improvement Committee
In addition, the Corporate Quality Improvement Committee (CQIC) oversees the quality improvement program, as delegated by the internal board/management team.

The impact and effectiveness of the quality improvement program is reviewed at least annually. This committee provides operational oversight for the quality improvement program's activities and recommends policy decisions. The CQIC facilitates integration of operational processes across the organization by planning, analyzing, and evaluating quality improvement activities. The CQIC promotes objective and systematic monitoring and evaluation of consumer and client health services and facilitates compliance with regulatory requirements.

Committee resources are in place to address problems or concerns that come to our attention through internal surveillance, complaints, or other mechanisms. The CQIC is responsible for review and approval of the Quality Improvement (QI) program description, QI annual evaluation, and QI work plan. The CQIC reports to the internal board/management team and is chaired by the corporate chief of quality. The CQIC meets at least monthly. Members of the CQIC include representatives from:

- Accreditation
- Appeals and Grievances
- Behavioral Health
- Claims
- Clinical Policy
- Clinical Strategy
- Clinical Programs
- Compliance
- Commercial Product Utilization Management
- Consumer Messaging
- Quality Operations, Compliance and Accreditation
- Credentialing
- Customer Service
- Disease Management
- Medicare Health Support Organizations (MHSO) Product Utilization Management
- National Network Operations
- Pharmacy
- Provider Communications
- Provider Contracting
- Risk Management
- Sales/National Accounts
- Quality Improvement and Stars Maximization

Provide utilization management services designed to authorize care with the fewest number of hospital days and/or elective surgeries such that quality of care and patient satisfaction are not reduced. Reviews to be conducted by staff consisting of registered nurses and a panel of physician advisors including specialists.

Confirmed. At Humana, the Utilization Management (UM) team takes the lead in discharge planning for all hospitalized members but collaborates with and refers members to telephonic care management.

Telephonic care managers will complete a comprehensive post-hospital evaluation that includes medication adherence/reconciliation, help with follow-up appointments and evaluation of other service needs [Durable Medical Equipment (DME), home health, transportation, etc.] and education needs.

Our clinical staff is made up of UM nurse clinical advisors, case managers, clinical social workers, community health educators, registered nurses, and licensed practicing nurses. Humana's evaluation of program effectiveness uses a propensity-matched study design to determine the impact of the program on utilization patterns. Humana telephonic care management targets those members on whom we can make real impact, based on analytics and claims. Our care management services reduce emergency room (ER) visits, hospitalization, and readmission rates – three key drivers of high medical costs for this age group.

The Humana telephonic care management program is designed specifically for our most at-risk members and has demonstrated the following successes:

- Reduction in high acuity readmissions after discharge by 18%, and when we conduct a medication reconciliation with it, it is reduced an added 13% for a total of 31% reduction. (*Note: A Humana trend analytics and forecasting statistical study completed in 2021 of Medicare Advantage members, compared to eligible Medicare Advantage control population matched on propensity-score*)
- Achievement of top Net Promoter Scores (NPS) scores among Humana offerings (*2021 NPS of 76-84 across programs) and health insurance industry (Note: InMoment NPS reporting from Dec 2021*)
- In 2021 we completed 53,000 care manager and pharmacist-led medication reconciliations (*Note: Humana care management operations report as of December 2021*)

Provide information on all programs that target treatment of chronic diseases, i.e., disease management. Discuss health assessment surveys, nurse interventions and health outcome data, different therapies used to treat different diseases and dissemination of data to network physicians.

Confirmed. Through our annual PlanCompass report, we share information with Jefferson Parish relating to your members' clinical services, Health Alerts, and preventive service reminders, as well as utilization metrics including medical admits, specialty medications, prescription drug benefits, large claims, per member per month (PMPM), overall cost to the member, preventive adherence, health alert adherence, SilverSneakers participation, and more.

Administrative Services
Establish, maintain, and update Master Record file(s).

Confirmed. We work closely with Jefferson Parish to ensure all retirees are covered as expected. If Jefferson Parish chooses to utilize EDI enrollment, we compare and contrast the eligibility files against the information in our system and provide a discrepancy report to keep you aware of any CMS terminations—including those due to death. The report shows members enrolled in the Humana plan but not active on Jefferson Parish's file, and vice versa. We also conduct membership audits for groups that do not use the electronic enrollment method. For this, Jefferson Parish must provide a spreadsheet of all retirees expected to enroll in the Humana plan for us to compare and contrast the data and report back any differences. Jefferson Parish also receives monthly invoices showing the active membership on the plan.

Reconciliation between Humana and CMS
On a daily basis, we send enrollment data to CMS and CMS sends back a file feed advising Humana on which members have been accepted or denied for enrollment in our Medicare plans. Our CMS Processing Unit reviews denial codes to identify denied members that could be accepted on Humana's plan. Discrepancies between Humana eligibility information and Medicare eligibility information are identified and worked on a case-by-case basis. We also have a Medicare Reconciliation department that helps ensure our system entries match those of CMS. Humana's enrollment representative dedicated to the Jefferson Parish plan keeps the Jefferson Parish retiree office alerted to these discrepancies to ensure everyone's system is aligned.

Prepare and print all plan documents:
a. Group Policy/ Plan Document
b. Summary Plan Description (SPD)
c. Other documents as may be required by federal state and local laws

Confirmed. Humana will prepare and make all plan documents available as required by Medicare. Plan documents will be distributed in accordance to CMS timeframes and as directed by Jefferson Parish. Documents not automatically distributed to members will be made available in print upon request or accessible online through Humana's secure member portal, **Humana.com**.

Furnish all standard forms to be used in connection with the administration of the plan:
a. Enrollment Forms
b. Claim Forms
c. ID cards
d. EOBs

Confirmed. Humana furnishes all standard forms to be used in connection with the plan administration. These include, but are not limited to, the following items:

Enrollment Kits and Enrollment Forms
These are made available as groups join Humana or renewal kits if there are benefit changes or new plan offerings as groups renew with Humana. Our enrollment kit typically includes:
- Welcome letter to retirees
- Enrollment application and return envelope or Enrollment Information Guide
- Guidebook
- Medical summary of benefits, including list of ancillary services
- Pharmacy summary of benefits
- Pharmacy Abbreviated Drug Guide
- CenterWell Pharmacy flyer (pharmacy mail-order service)
- Go365 flyer (Humana's health and wellness program)
- Member to provider flyer (passive/transitional PPO plans)
- Seminar invitation (if applicable)

Claim Forms
Members can access direct member reimbursement claim forms online at **Humana.com.**

ID Cards
ID Cards a issued within 10 days of enrollment acceptance to all members. Replacement ID cards are issued within five days of request.

Explanation of Benefits
Each month, members also receive a statement of their personal health benefits which provides a full picture of the member's use of healthcare services and associated costs, such as doctor's visits, lab work, therapies, hospitalizations, medication, copayments, and deductibles. By showing retirees how exactly they're using their benefits, we better engage them in their spending and help them to decide about how best to utilize their benefits going forward.

Review, in a consultative capacity, summary plan descriptions and other similar material to be distributed to plan participants.

Confirmed. Humana follows CMS' regulations when preparing and issuing the EOC booklet for our Medicare Advantage members. Jefferson Parish's account installation manager (AIM), Maisie Mitchell, will provide the EOC for approval prior to distribution. While customizations to the EOC are limited to those as permissible by CMS, Maisie will provide a consultative review of the EOC for accuracy of benefit representation prior to distribution.

New members will receive a printed copy of their EOC within 30 days of the plan effective date for the initial plan year.

For renewing members, Humana sends members a printed copy of their ANOC booklet. Timing of issuance is prior to the renewal effective date of the plan.

Members have the option to order printed mailed copies of the EOC/ANOC online at **Humana.com/plandocuments** or by contacting the customer service phone number located on the back of their Humana ID. Digital copies of the EOC are also viewable online through the secure member portal, **MyHumana**.

Consult on plan provisions, plan design, impact of local, state, or federal legislation, new medical procedures/technology, emerging benefits trends, cost containment, and other ongoing services issues.

Confirmed. An advantage of moving to a PPO product is access to comprehensive reporting on the performance of your plan. Please refer to Attachment C for a sample PlanCompass reporting package.

Humana's Group Medicare PlanCompass report evaluates the performance of Jefferson Parish's health plan. The broad spectrum report addresses the overall health services utilization of the plan, integrating information about demographics, wellness and preventive services, clinical health programs, very high cost claimants, and pharmacy. By evaluating these areas and comparing plan use and performance to market and national benchmarks, or norms, Jefferson Parish is able to better understand how your members and retirees utilize health services.

The PlanCompass is typically delivered on an annual basis. The standard reports we provide include:

- **Demographics**
  - Demographic Key Indicators
  - Membership distribution by age and gender
  - Spend distribution by age and gender
  - Member contact and web utilization
- **Wellness**
  - Clinical program participation
  - Health alert compliance
  - Wellness and preventive screenings
- **Spend and Utilization**
  - Emergency, urgent care, and ancillary services
  - Inpatient and outpatient care
  - Large claimants impact
  - Physician office visits
  - Utilization trend scorecard
  - Clinical condition prevalence
  - Detailed review of top three conditions
  - Top 10 clinical conditions
  - Cost Share
- **Pharmacy**
  - Prescription utilization summary
  - Tier Distribution
  - Specialty Drug Impact
  - Top 25 Drugs

Your assigned Account Management team reviews the results of Jefferson Parish's specific PlanCompass report, including the identification of cost and utilization trends and recommended action steps. The medical director assigned to Jefferson Parish is a key member of this team and provides clinical observations and recommendations. Indications of overuse of specific benefits allow Jefferson Parish to adjust the plan and encourage members and retirees to seek health services in the appropriate healthcare settings by further engaging them in their healthcare decisions.

Performance Standards
Proposer shall maintain the following performance levels, as applicable:
Eligibility Loading- Load all eligibility files into system within five (5) business days of receipt. Measurement Criteria- Elapsed time from date file received to the date upon which the file is loaded to the eligibility system.

Confirmed. Please refer to Section X for Performance Guarantees.

ID Cards - mailed within ten (10) business days after final member eligibility is received, system loaded and passes a quality assurance check. Measurement Criteria - Date ID cards are mailed.

Confirmed. Please refer to Section X for Performance Guarantees.

Electronic "Claim Ready Date"- Electronic Claim Ready by the effective date or within twenty (20) business days after account structure is entered into the system, final member eligibility is received, and benefit plan design is finalized. Measurement Criteria - Date plan benefits and employee and dependent eligibility data is system loaded.

Confirmed. Please refer to Section X for Performance Guarantees.

Claim Operations: Measurement Criteria- by standard claim operations reports:
Time to Pay- 90% of "non-controversial' or "clean" claims paid in ten (10) business days

Confirmed. Please refer to Section X for Performance Guarantees.

Financial Accuracy- 99% of submitted charges processed correctly

Confirmed. Please refer to Section X for Performance Guarantees.

Procedural Accuracy- 95% of claims processed without non-financial error

Confirmed. Please refer to Section X for Performance Guarantees.

Penalties: The annual penalty for failure to maintain the performance levels above shall be:

Eligibility Loading	**$20,000**
ID Cards	**$50,000**
Electronic "Claims Ready Date"	**$50,000**
Time to pay	**$50,000 for failure to pay 90% of claims within 10 days; Increase $5,000 per extra day to meet 90% standard to a maximum of 15 days and maximum of$100,000.**
Financial Accuracy	**$100,000 for failure to process 99% of claims correctly; Increase $5,000 per 25% reduction in accuracy to 98% and maximum of $200,000**
Procedural Accuracy	**$20,000 for failure to process 95% of claims without a Non-financial error; increase $5,000 per .50% reduction in accuracy to 93% and maximum of $40,000.**

Humana agrees to meet the performance standards as outlined in Section X, Performance Guarantees, while administering the Group Medicare Advantage Plan for Jefferson Parish. This agreement is contingent upon a minimum average enrollment with Humana of 500 members with Humana being the only Medicare Advantage option for Medicare eligible retirees. The agreement will be for the contract period beginning January 1, 2023 and ending December 31, 2023. As part of this agreement, Humana is willing to place an annual maximum at risk of $410,000 dependent upon minimum average enrollment, for failure to meet the stated performance standards. This Performance Guarantee offering is based on an MA Only or MAPD plan offering. Performance results will be reported quarterly based upon center results for the member and claims services categories, not client-specific results (except where otherwise stated) within 60 days after the end of the reporting period. Results will be assessed based on the annual results with payment of any penalties due following the end of the plan year. Please note that the performance standards are influenced by key market indicators (including changes in rules and standards from CMS) which could impact our performance standard metrics.

With respect to financial accuracy and processing accuracy, data is obtained through ongoing random audits based on a statistically valid sampling of all claims represented for payment.

During implementation/renewal if significant changes to the Client's Plan, or in the event a benefit change notification is not received from the Client on a timely basis, Humana will not be responsible for performance results or penalty amounts as described within this Agreement.

Claims Processing Services
Maintain and update eligibility file.

Humana has a proven ability to manage eligibility in accordance to rules established by Jefferson Parishh using best practice processes developed over our nearly 30 years of working with CMS. During the implementation/renewal process, we will share these practices and processes annually with Jefferson Parish staff and refine a work plan for managing these issues that continues to be tailored to your specific needs and capabilities.

Humana follows CMS' enrollment guidelines relating to specific eligibility scenarios (i.e., ESKD, no Part B, retro disenrollment, retro enrollment, etc.) and we have developed processes for successfully managing each scenario to keep records current.

To work with Jefferson Parish on these issues, we have a designated enrollment analyst, Annie Eckert, who will work directly with Jefferson Parish to immediately review and address any concerns/questions and explain why a member is being denied/rejected. Annie works directly with our Critical Processing Unit to file cases with CMS to correct enrollment issues. Annie is up-to-date on CMS' requirements for retro requests and can provide guidance to the group on specific scenarios.

A regular cadence of eligibility reports are provided to ensure records are synced and discrepancies quickly identified. Humana has flexibility around the frequency and format of reporting to ensure the needs of Jefferson Parish are met.

For our groups using electronic enrollments, we compare and contrast full eligibility files sent. We create a discrepancy report from the results, showing which retirees do not match between our system and the EDI file. This report also shows which demographic fields require corrections to be made on the EDI file.

Humana systematically completes membership reconciliation at multiple levels.

Reconciliation between Humana and Jefferson Parish: Humana will work closely with Jefferson Parish to ensure all the retirees are covered as expected. Groups that use EDI as the enrollment method will receive a discrepancy report when Humana receives full eligibility files for processing. Humana reports back after comparing and contrasting the group's file against the information in Humana's system for the group. The report will show any members that are enrolled in the Humana plan, but not active on the group's file, and vice versa. This report helps keep Jefferson Parish aware of any CMS terminations, including terminations due to death.

Reconciliation between Humana and CMS: Humana's process with CMS for reconciling Medicare enrollments is continuous. Humana sends enrollment data to CMS daily to communicate enrollment submission. CMS sends Humana a file feed six days a week that advises who has been accepted and denied for enrollment in Humana Medicare plans. Humana has a CMS Processing Unit that reviews denial codes in order to identify those denied members that could be accepted on Humana's plan. Humana also has a Medicare Reconciliation department that works to ensure Humana's system entries match those of CMS.

Discrepancies between Humana eligibility information and Medicare eligibility information are identified and worked on a case-by-case basis.

Administer the plans' Coordination of Benefits (COB) provision.

Confirmed. Humana receives other insurance information from the Coordination of Benefits Coordinator for CMS. They collect data from all insurance companies. The Coordinator determines if the member has other insurance or not and dictates which policy is primary versus secondary on behalf CMS.

Coordinate payment of benefits with Medicare when applicable.

Confirmed.

Review claims submitted for medical services that appear excessive and/or establish medical necessity for services rendered or expenses incurred.

Confirmed. The purpose of Humana’s system edit programs is to identify questionable eligibility or claim data, coordinate benefit opportunities, and detect unbundled or duplicate charges as well as potential third-party liability or fraudulent claims. Our internal subrogation and fraud departments are an integral part of our commitment to reduce unnecessary expenses and minimize recovery activity.

Our claims processing system routinely performs the following automatic audits:

- Patient’s gender and age are consistent with the procedure and diagnosis codes
- Diagnosis code and procedure code are consistent with each other
- Date of service
- Procedure code and diagnosis code are valid
- Claimant is a covered retiree
- Precertification was obtained as required (when applicable)
- Service is medically necessary and review is not required to determine appropriateness
- Claim is a not candidate for audit
- Active coverage
- Total disability
- Other insurance

Several of our claim cost control efforts include:

- **Duplicate charges**: Our automated claim system detects duplicate submissions based on specific criteria, such as dates of service, current procedural terminology (CPT-4) codes, provider, place of treatment, and billed charges. When the criteria in one claim matches a claim previously processed, the system automatically rejects the second claim as a duplicate. If there is sufficient similarity between the data,

the claim specialist receives a "suspect duplicate" edit preventing payment. Claim history must be reviewed for further verification. If the specialist recognizes the claim as being a duplicate, the claim is rejected. In the event the claim is not a duplicate, the edit is overridden by the specialist and the claim is processed.

- **Hospital bill audits**: Trained claim personnel in our Fraud and Abuse unit and the Financial Recovery unit conduct in-depth claims scrutiny for providers who consistently overcharge or perform unnecessary procedures. These teams use a variety of complex methods to identify offenders including ad hoc reports, provider trend analyses, and personal referrals or tips. Our hospital contracts contain a combination of reimbursement methods, including per diems, flat fees, case rates, and diagnosis related group (DRG). Of these arrangements, per diems are the most prevalent reimbursement method currently used; however, we are shifting hospital contracts to a DRG-based reimbursement when possible. We use DRG coding software from 3M and HSS to ensure that the diagnoses and procedures actually performed correspond to the DRG billed by the hospital. Additionally, our hospital audits review whether the diagnoses and procedures are supported by the medical record.
- **Unbundling**: Our code editing software identifies coding and billing errors, including excessive billing, fragmented billing, unbundling, incidental procedures, incorrect use of codes for procedures specific to age, and/or gender and cosmetic procedures. In most cases, the claim system automatically rebundles, corrects, or denies incorrect billings. If additional follow-up is needed, a specialist flags the claim for manual review. When necessary, our Special Investigations unit (SIU) pursues suspicious providers. This unbundling software is invoked systematically whenever a service is billed using standard procedural terminology (CPT-4, HCPCS, and ICD) codes, and the logic is updated regularly to reflect changes in the code sets.
- **Unnecessary medical treatment**: We review medical necessity based on clinical information regarding the member's condition and treatment plan on a prospective, concurrent, or retrospective basis, evaluated within the timeframe required for each new review type. The UM nurse analyst utilizes InterQual® guidelines and Solucient® length of stay guidelines as well as internal criteria as the basis to review the request. If there is a question as to whether the hospitalization or procedure is medically necessary, the nurse analyst forwards the case to a medical director for review. When a specific treatment plan does not meet medical criteria, the medical director refers the case to a peer clinical reviewer for peer-to-peer discussion.

Make available the services of field claim consultants and/or professional services resources for the evaluation of complex claims.

Confirmed. Your account concierge specialist (ACS), Courtney Bell, is your point of contact for complex claim issues or any claims escalated through customer service. If a provider is in need of assistance or education regarding complex claims, our local provider contracting team will support that effort.

Maintain peer review relations.

Confirmed.

Discuss disputed charges with providers when appropriate.

Confirmed. If a member receives a balance bill from a contracted provider for an amount other than the copayment or coinsurance amounts (excluding non-covered services or in instances wherein plan guidelines

have not been met, e.g., if a referral has not been received), they should contact Humana Customer Care for assistance. A Humana Customer Care specialist will attempt to resolve the issue with the provider's office to ensure that the member is not held financially responsible for any amount not designated as "member responsibility." If the provider believes they are not contractually obligated to write off the balance of charges above the contracted allowable amount, their disputes are addressed by our Provider Affairs Complex Resolution unit, which only becomes involved if a balance billing trend is identified with a specific provider.

Must notify JPG of any and all PPACA changes and updates that will impact JPG financially and administratively.

Confirmed. As part of the routine Account Management updates provided to Jefferson Parish, Humana would provide legislative updates during the meetings noted in our RFP response. Account Management works closely with Humana's Corporate Affairs team and will be able to provide updates as they become known to us tied to regulatory or legislative changes, in addition to annual CMS updates and changes that come out of the Advance Notice in February and Final Call Letter in April.

Maintain and store claim detail data elements for statistical analysis.

Confirmed.

Provide online and mobile claim viewing access to participants.

Confirmed. Members can view the status of a claim by logging on to the secure personal member web portal, MyHumana, or by calling the toll-free Customer Care number.

By signing in to MyHumana, members can easily find their Humana member ID, get information on their coverage, claims and spending account information, find an in-network provider, or get reminders for care they may need to achieve their best health. Members can activate or sign in to their MyHumana account by going to **Humana.com** and clicking "Sign in."

Coronavirus

- Get timely information on member benefits related to COVID-19
- Find resources for prevention, or if the member is experiencing symptoms
- See information on telehealth (also called virtual visits)
- Find community resources related to basic needs

Coverage and Claims

- View coverage, benefits and plan details, including coverage and out-of-pocket responsibility
- Get information on claims and claim status, amount owed – if any, download claims and view year-to-date information
- See SmartSummary Statements and Smart EOBs
- Find information on special discounts and savings
- View accumulations on deductibles and out-of-pocket maximums (if applicable)

Health and Wellness

- Get reminders to complete screenings or other preventive health care that can help the member achieve their best health
- Find out how to use telehealth for getting care
- Download Blue Button health data – a record of a member's PHI – including information on current conditions, prescription history, or lab history
- Access health tools for surgery planning and creating a checklist of things to talk about with their doctor
- Find information on Humana health programs
- For members with diabetes: Get a personalized page on diabetes that displays health stats and related health improvement messages
- (If applicable) See information on Go365, and easily navigate to the Go365 member site

Pharmacy

- Robust pharmacy information and tools help members understand what's covered, the estimated cost of a drug at retail pharmacies and mail-order, prior authorization status, drug alternatives, and drug library and drug interaction tools
- RxMentor® lets members store and keep track of their medicines and allergies all in one place. Members can populate their medication list using their previous claims and have the opportunity to edit their list, add OTC medications, and print the list to share with their doctor.
- Humana will also inform members of savings opportunities

Account Management

- Set communication preferences to inform Humana how they would like to receive communications
- Manage email address and password
- Share access to PHI with someone else; manage shared access
- Request support for accessibility needs, such as hearing impairment or visual impairment

Billing

- Make premium payments, or set up automated recurring payments
- Set or change payment method
- View billing account balance and history

Help, Support & Tools

- ID card center: view, print and order Humana member ID cards from a central location
- Find a doctor tool: easily search for in-network doctors, dentists, specialists, urgent care centers, hospitals or pharmacies. Members can search by name, specialty or condition.
- Chat with a Humana representative
- Ask Humana/Ask the Pharmacy – Search for answers to questions, take action from answer text, and see related questions
- Use the Contact us page to easily find the right phone numbers if a member needs to contact Humana

Other

- Responsive website design provides an optimized experience for various screen sizes including mobile devices and tablets
- MyHumana is also available in Spanish

Our MyHumana mobile app allows members to manage healthcare needs virtually anywhere, anytime. Accessible on any smartphone device, members can download the MyHumana app. Through our mobile app, Medicare members can:

- Access medical, pharmacy and dental ID cards
- Send their ID card to their provider through fax or save the image to their photo gallery
- Find a doctor, pharmacy, dentist, hospital, urgent care center or retail clinic. Members can use their current location to find the closest in-network provider – no matter where they are. Providers can be filtered with a set of different criteria.
- Search prescription and over-the-counter drugs and price them (must be ordered on the Humana Pharmacy app)
- Manage list of prescription and over-the-counter drugs that user is currently taking using the MyMeds flow.
- View medical, dental, and pharmacy claims
- View HumanaAccess spending account information
- View plans and coverage details, including deductibles
- Pay bill balances
- Find a telehealth provider
- Get information and resources on the COVID-19 pandemic

New Business Installation Services
Consult on new products, alternate health care delivery system, and healthcare cost management techniques.

Confirmed. Your Account Management team will discuss insights regarding new products, healthcare management trends and cost management techniques during your annual PlanCompass meeting and at renewal discussions.

Participate in and/or conduct employee meetings as requested.

Confirmed. Humana will coordinate, host, conduct and/or join employee meetings as requested.

Humana also offers Bringing Humana to You (BH2U) meetings to our clients. These are planned throughout the year to bring retirees to either Humana in the Community, SilverSneakers facilities, or other client or community facilities to educate members on their benefits, clinical and health and wellness programs, and other condition management topics. It's a great way for retirees to come out and meet with Humana to ask questions and better understand their benefit, ask claims questions, and learn more about plan services.

During these meetings, we:

- Promote SilverSneakers
- Educate members about our Humana Care Management programs
- Share other resources available

These meetings can coincide with a retiree association or any regularly scheduled meeting, or we also offer BH2Us as stand-alone meetings.

Act as a liaison with administrative, technical services, and claims departments.

Confirmed. Our Group Medicare Operations unit, created over 10 years ago, was the industry's first customer service team and call center dedicated completely to serving Group Medicare Advantage customers. Service to Jefferson Parish and other customers is organized around teams, each of which is led by an AIM who works extremely closely with a set of customers and their Humana account executives to coordinate plan implementations. Your AIM, Maisie Mitchell, then continues after implementation/renewal as our customers' daily inside connection to our Group Medicare operations and customer service. On the team is a communications consultant, billing consultant, IT specialist, and others.

Jefferson Parish's assigned ACS, Courtney Bell, provides service issue resolution for Jefferson Parish's claimants when standard-issue resolution processes are not functioning properly. Once implementation/renewal is complete, your senior account executive, Erin Dey, and Maisie meet with Jefferson Parishto discuss any outstanding concerns. After these wrap-up meetings, both Erin and Maisie remain your points of contact for all ongoing support questions. Courtney also works directly with the Account Management team to identify and resolve escalated client issues. Identified issues are shared with Customer Care specialists.

Additionally, your ACS, Courtney Bell, identifies trends and communicates internally with the Account Management team. This ongoing dialogue can ultimately create strategic and educational opportunities for Jefferson Parish's retirees.

If you are awarded the contract, you will be responsible for developing, printing and distribution of the required ID cards, claim forms, provider directories and employee booklets. Any cost for these services must be absorbed by the proposer.

Confirmed. Humana will develop, print and distribute the required ID cards, claim forms, provider directories, and enrollment materials at no cost to Jefferson Parish. Humana is open to learning more about your vision for the employee booklets and discussing ways we can best support Jefferson Parish in their development and distribution.

Other Services
Provide a network of physicians, hospitals and other health care professionals and providers offering discounts or special fee arrangements to their normal service fee schedules.

Confirmed. Humana is well-positioned to offer Medicare Advantage PPO and HMO products to Jefferson Parish that cover your Medicare-eligible retirees with over 900,000 providers in all 50 states, Puerto Rico, and Washington D.C. through our broad PPO network. These plan designs allow us to take advantage of our Medicare Stars rating to provide competitive rates for retirees, which enhances member activation and engagement in wellness and chronic condition management programs, care management compliance and cost effectiveness, and our ability to more effectively manage medical cost trends.

We also cover individuals living outside our Medicare Advantage PPO service areas under our Medicare Advantage PPO Expansion Waiver with CMS. This waiver permits us to provide traditional or passive Medicare Advantage PPO benefits to these members and results in 100% of all members being provided a single, uniform, national plan of benefits.

Value-based reimbursement is the foundation on which Humana developed our accountable care continuum where physicians are paid based on patient health outcomes and experiences instead of receiving fee-for-service reimbursement. Value-based care has offered the business context for payers and healthcare providers to align incentives and to consistently focus on what is most important for patients. The continuum recognizes practice complexity by offering several levels of participation in Humana's Provider Quality Rewards Program, including Star Rewards, Model Practice, and Medical Home.

Humana has extensive experience partnering with providers in accountable care relationships. As of January 1, 2021; 67,800 PCPs have value-based relationships with Humana, resulting in more than 1,000 agreements in 43 states and Puerto Rico. Of Humana's individual Medicare Advantage membership, 67%, or 2.65 million, seek care from PCPs in value-based agreements.

Humana's experience in value-based arrangements leads to higher quality care. Physicians in Humana Medicare Advantage value-based agreements are achieving higher rates of patient engagement in preventive screenings, medication adherence, and management of chronic conditions as measured by HEDIS. While we know that all physicians are committed to patient health, those in value-based care agreements have access to additional resources and capabilities to build the infrastructure they need to expand their reach outside the practice. Focusing on prevention and the whole health of their panel population allows physicians and their care teams to work more strategically to improve the care of their patients. Going forward, we need to continue to build on the fabric of team-based care, sealing off clinical silos. Team-based interdisciplinary care, quarterbacked by PCPs, will be a differentiator in that effort.

This consistency of care sharply reduces incidence of hospital admissions and ER visits. Hospitalization avoidances were 22% less in Humana Value-based Care relationships and 4% fewer ER visits when compared to Original Medicare. Humana Medicare members aligned with providers in value-based plan arrangements have better outcomes, lowers costs, and higher quality scores:

Preventive screenings (Value-based PCPs compared to non-value-based PCPs):

- 8% more screenings conducted overall
- 19% more colorectal screenings and diabetic eye exams
- 22% more post-discharge medication reconciliations

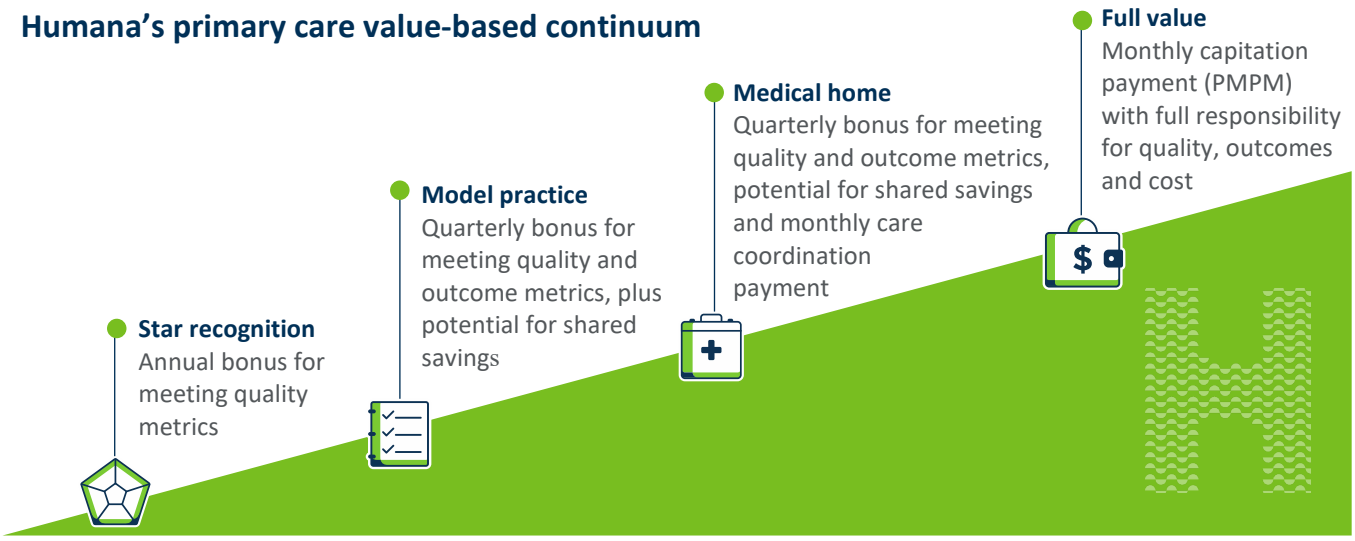
Lower Costs

- 13.4% lower medical costs
- 3.1 billion more costs if in a fee-for-service network

Higher Quality Scores

- 13% higher overall HEDIS scores
- 90+% retention Medicare Advantage members in value-based settings

Humana's experience in partnering with physicians in value-based arrangements ensures your members have access to high-quality providers and creates a sustainable Medicare Advantage program.



Please refer to our annual Value-based Care report to learn more about Humana's commitment to value-based contracting: https://valuebasedcare.humana.com/

A dedicated nationwide toll-free customer service line specifically for retirees of the Parish is required.

Confirmed. Humana Group Medicare will have a dedicated nationwide toll-free customer service line for the employees of Jefferson Parish. Our Group Medicare member service hours of operation are 8 a.m. to 9 p.m. Eastern time, Monday through Friday.

Humana has three main Customer Service Centers that support our Group Medicare clients and retirees: one in Louisville, Kentucky, one in Cincinnati, Ohio, and another in Tampa, Florida. We find great success in having multiple service centers supporting our Group Medicare unit, creating an effective business continuity plan in the event of an issue or closure.

Humana also leverages fully trained Group Medicare staff from two satellite sites: Montgomery, Alabama and Charlotte, North Carolina. These associates can quickly pivot to support our Group Medicare Service centers in times when additional support may be needed, such as months with higher call volumes. All our Customer Service associates are also fully equipped for successfully working remotely from their homes.

We also have pre-enrollment, toll-free Medicare Customer Care units located in Tampa, Florida and Madison, Wisconsin. These units are comprised of licensed sales agents who have undergone client-specific training to best service our Group Medicare accounts and members. They answer benefits questions and explain the enrollment process for Medicare eligible employees and retirees interested in the Humana plan. The hours of operation are 8 a.m. to 8 p.m. Eastern time, Monday through Friday. Our open enrollment and general Customer Care teams are accessible via the same toll-free number.

For members needing assistance after hours, we have a 24-hour IVR system that can assist members with commonly asked questions and requests. Members can verify benefits and eligibility; check a claim status; request ID cards; obtain proof of coverage provider directory and plan benefit documents, initiate or check

state on pre-certification; and inquire on billing. Extensive self-service functions are also available on our website, **Humana.com**.

JPG reserves the right to return to the top candidates to request a final proposal based on one or more components of the initial proposal. JPG reserves the right to negotiate certain terms and conditions relative to the contract.

Understood and agreed.

ATTACHMENT A

GENERAL PROFESSIONAL SERVICES QUESTIONNAIRE

General Professional Services Questionnaire Instructions

- The General Professional Services Questionnaire shall be used for all professional services except outside legal services and architecture, engineering, or survey projects.
- **The General Professional Services Questionnaire should be completely filled out. Complete and attach ALL sections. Insert "N/A" or "None" if a section does not apply or if there is no information to provide.**
- Questionnaire must be signed by an authorized representative of the Firm. Failure to sign the questionnaire shall result in disqualification of proposer pursuant to J.P. Code of Ordinances Sec. 2-928.
- All subcontractors must be listed in the appropriate section of the Questionnaire. Each subcontractor must provide a complete copy of the General Professional Services Questionnaire, applicable licenses, and any other information required by the advertisement. Failure to provide the subcontractors' complete questionnaire(s), applicable licenses, and any other information required by the advertisement shall result in disqualification of proposer pursuant to J.P. Code of Ordinances Sec. 2-928.
- If additional pages are needed, attach them to the questionnaire and include all applicable information that is required by the questionnaire.

General Professional Services Questionnaire

A. Project Name and Advertisement Resolution Number:

SOQ No. 22-037, Group Medicare Advantage Plan with a Nationwide Provider Network for all Medicare Eligible Retirees and Dependents

B. Firm Name & Address:

Humana
500 West Main Street
Louisville, Kentucky 40202

C. Name, title, & contact information of Firm Representative, as defined in Section 2-926 of the Jefferson Parish Code of Ordinances, with at least five (5) years of experience in the applicable field required for this Project:

Erin Dey
Senior Account Executive
4 Oakley Drive
Destrehan, Louisiana 70047
504-343-0158
edey@humana.com

D. Address of principal office where Project work will be performed:

500 West Main Street
Louisville, Kentucky 40202

E. Is this submittal by a JOINT-VENTURE? Please check: **YES** ☐ **NO** ☑

If marked "No" skip to Section H. If marked "Yes" complete Sections F-G.

F. If submittal is by JOINT-VENTURE, list the firms participating and outline specific areas of responsibility (including administrative, technical, and financial) for each firm. Please attach additional pages if necessary.

1.

2.

General Professional Services Questionnaire

G. Has this JOINT-VENTURE previously worked together? Please check: YES ☐ NO ☐

H. List all subcontractors anticipated for this Project. Please note that all subcontractors must submit a fully completed copy of this questionnaire, applicable licenses, and any other information required by the advertisement. See Jefferson Parish Code of Ordinances, Sec. 2-928(a)(3). Please attach additional pages if necessary.

Name & Address:	Specialty:	Worked with Firm Before (Yes or No):
1. Not applicable; Humana performs all core services included in this proposal		
2.		
3.		
4.		
5.		

General Professional Services Questionnaire

I. Please specify the total number of support personnel that may assist in the completion of this Project:
6

J. List any professionals that may assist in the completion of this Project. If necessary, please attach additional documentation that demonstrates the employment history and experience of the Firm's professionals that may assist in the completion of this Project (i.e. resume). Please attach additional pages if necessary.

PROFESSIONAL NO. 1

Name & Title:

Tiffany Calderon, Director of Account Management, Group Medicare

Name of Firm with which associated:

Humana

Description of job responsibilities:

Oversees an Account Management team focused on exceeding customer expectations, retaining membership, identifying opportunities to add value to clients, and generating growth for Humana

Years' experience with this Firm:

17 years

Education: Degree(s)/Year/Specialization:

- University of Houston; Bachelor of Science – Psychology
- Insurance State License; Life, Health and Accident
- Resident License – Texas
- AHIP Certification

Other experience and qualifications relevant to the proposed Project:

Tiffany has spent the last 24 years building strong relationships across the insurance industry, specifically in sales and account management. Tiffany focuses on strong client professionalism and brings experience and knowledge managing large public sector clients to her team every day. She also has an eye for detail and a robust understanding of government contracts.

General Professional Services Questionnaire

PROFESSIONAL NO. 2

Name & Title:

Erin Dey, Senior Account Executive

Name of Firm with which associated:

Humana

Description of job responsibilities:

- Works strategically with consultants, business leaders, and internal associates to provide excellent benefits and service
- Services numerous clients and retirees across the United States
- Manages both post- and pre-65 retiree plans for national organizations and labor groups
- Responsible for overall client experience and relationships with Humana

Years' experience with this Firm:

18 years

Education: Degree(s)/Year/Specialization:

- Tulane University; Bachelor of General Studies
- Insurance State License; Life, Health and Accident
- Resident License – Louisiana
- Non-Resident Licenses – Arkansas, California, Connecticut, Florida, Georgia, Illinois, Kentucky, Maryland, Michigan, New Jersey, New York, South Carolina, and Texas
- AHIP Certification

Other experience and qualifications relevant to the proposed Project:

Erin started in the healthcare industry by managing the day-to-day operations of a 4,000-member self-fund health plan. She transitioned from being the client to servicing the customer at a former Louisiana-based health insurer. From there, she progressed into account management and held various operational roles. Erin brings her well-rounded experience and client understanding to her Group Medicare clients.

General Professional Services Questionnaire

PROFESSIONAL NO. 3
Name & Title:
Maisie Mitchell, Account Installation Manager
Name of Firm with which associated:
Humana
Description of job responsibilities:
• Oversight and responsible for overall implementation/renewal, including planning, strategizing, and communication of customized client-specific project plans • Coordinates internal operational resources for planning and execution of overall project from point of sale through the effective date • Schedules regular implementation/renewal calls with internal and external clients to strategize implementations/renewals
Years' experience with this Firm:
2 years
Education: Degree(s)/Year/Specialization:
Other experience and qualifications relevant to the proposed Project:
Maisie began her career at Humana in 2020 as a Group Medicare Consumer Engagement Professional, focusing on planning and implementing member seminars to educate members on their benefits and additional resources available to them through their Group Humana plan. She quickly mastered the role, and in 2021, Maisie began working as a Group Medicare Account Installation Manager.

General Professional Services Questionnaire

PROFESSIONAL NO. 4
Name & Title:
Christah Sykes, Group Medicare Communications Consultant
Name of Firm with which associated:
Humana
Description of job responsibilities:
Serves as a designated Group Medicare employer point of contact assisting with escalated issues related to claims, benefits, billing, enrollment, and pharmacy
Years' experience with this Firm:
15 years
Education: Degree(s)/Year/Specialization:
• Mid-Continent University; Bachelor of Science, Business Administration – Cum Laude • Insurance State License; Life, Health and Accident • Resident License – Kentucky
Other experience and qualifications relevant to the proposed Project:
Christah began her Humana career in April 2007. She started servicing Individual Medicare members and was quickly identified to be a mentor for her peers. Christah shares a passion for helping members understand and recognize how to utilize their health plan effectively. In 2014, Christah was requested to join an elite team of associates that serviced one of Humana's largest clients.

General Professional Services Questionnaire

PROFESSIONAL NO. 5
Name & Title:
Courtney Bell, Account Concierge Specialist
Name of Firm with which associated:
Humana
Description of job responsibilities:
• Serves as a single point of contact for Group Medicare clients, supporting the customer in any service situation for any product in that customers plan • Researches and resolves complex group-specific issues, analyzes to find root cause, and drives process improvements
Years' experience with this Firm:
10 years
Education: Degree(s)/Year/Specialization:
Other experience and qualifications relevant to the proposed Project:
Courtney began her Humana career in 2012 as an operational specialist working enrollment or eligibility issues. She quickly advanced to a skilled Customer Care specialist providing perfect service for members. Because of her ability to adapt quickly and her dedication to service, Courtney joined the Group Medicare Account Concierge team in 2015. In this role, she used her experience in customer service to resolve escalated issues for our members as efficiently as possible. Courtney also provides top-notch support at many Humana meetings throughout the country.

General Professional Services Questionnaire

PROFESSIONAL NO. 6
Name & Title:
Annie Eckert, Enrollment Analyst
Name of Firm with which associated:
Humana
Description of job responsibilities:
• Researches and responds to enrollment inquiries from both internal and external partners, including group representatives • Collaborates with multiple internal departments to ensure a seamless enrollment experience for our members and clients • Reviews and provides enrollment reports to groups, including discrepancy reports, membership reports, critical error and incomplete enrollment reports • Possesses a thorough understanding of the various CMS enrollment rules and guidelines and educate clients accordingly • Assists clients with ensuring Open Enrollment files are received and processed in a timely manner
Years' experience with this Firm:
12 years
Education: Degree(s)/Year/Specialization:
• Purdue University, Global – Bachelor of Science in Health Science candidate, 2023
Other experience and qualifications relevant to the proposed Project:
Annie Eckert is an Enrollment Analyst with the Group Medicare Operations department at Humana. Hired in 2010, Annie has spent her entire tenure with Humana in the Medicare realm, working in both Individual and Group Enrollment, as well as the Plan Load department where her responsibilities included interpreting and processing member benefit information. Annie's strengths include exceptional communication skills, Microsoft Office skills, and the ability to empathize with her members and groups. She is currently pursuing her Bachelor of Science in Health Science degree from Purdue University and intends to graduate in the fall of 2023.

General Professional Services Questionnaire

K. List all prior projects that best illustrate the Firm's qualifications relevant to this Project. Please include any and all work performed for Jefferson Parish. Please attach additional pages if necessary.	
PROJECT NO. 1	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Currently, Humana is providing Medicare Advantage, MAPD and/or PDP only plans to 272 public sector groups. Of those groups, 43 are of similar size to Jefferson Parish. Within our response to the Carrier Questionnaire, we have provided three references and those are included in more detail on this form.	
Length of Services Provided:	**Cost of Services Provided:**

PROJECT NO. 2	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Jefferson Parish Government Jefferson Parish, Louisana Jessica Palermo jpalermo@jeffparish.net (504) 736-6131	Medicare Advantage with Prescription Drug Benefits; create communication pieces for the parish to place on website in lieu of retiree meetings during the pandemic; attend retiree meetings and only carrier to support retiree association meetings when asked to attend.
Length of Services Provided:	**Cost of Services Provided:**
17 years	Approximately $1,900,000 per year

General Professional Services Questionnaire

PROJECT NO. 3	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
City of Newport News Newport News, Virginia Brian Sypolt sypoltbj@nnva.gov (757) 926-8499	PPO MAPD plan, 1,362 total membership; attend member meetings as requested; provide materials as requested for retiree events
Length of Services Provided:	**Cost of Services Provided:**
9 years	Approximately $5,100,000 per year

PROJECT NO. 4	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Gwinnett County Government Lawrenceville, Georgia Karissa Ogburn Karissa.ogburn@gwinnettcounty.com (770) 822-7912	PPO MAPD plan, 1,414 total membership; as a new group, conducted several informational meetings; planned Bringing Humana to You meetings to encourage Go365; holding a Medicare 101 training session for retirees aging in to Medicare; attending and assisting with coordinating extra support at annual health fair to include mobile mammography and other services such as SilverSneakers demonstration
Length of Services Provided:	**Cost of Services Provided:**
1 year	Approximately $2,200,000 per year

General Professional Services Questionnaire

PROJECT NO. 5	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Lafourche Parish School Board Thibodaux, Louisiana Chastity Himel chimel@mylpsd.com (985) 435-4658	PPO MAPD plan, 1,070 total membership; held Bringing Humana to You meetings for retirees and attended retiree association meetings
Length of Services Provided:	**Cost of Services Provided:**
3 years	Approximately $2,800,000 per year

PROJECT NO. 6	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
St. Charles Parish School Board Darrinisha Gray dgray@stcharles.k12.la.us (985) 785-7295	Commercial PPO for active employees; MAPD PPO for retirees with Medicare
Length of Services Provided:	**Cost of Services Provided:**
14 years	Approximately $15,000,000

General Professional Services Questionnaire

PROJECT NO. 7	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Other groups:	St. Tammany Parish School Board, MAPD HMO and PPO; Dental for active employees Length of Service - 14 years Iberville Parish School Board, MAPD PPO Length of Service – 13 years Lafayette Parish School System, MAPD PPO Length of Service – 14 years St. James Parish School Board, MAPD PPO Length of Service – 14 years State of Louisiana, MAPD HMO Length of Service – 4 years
Length of Services Provided:	**Cost of Services Provided:**

PROJECT NO. 8	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

PROJECT NO. 9	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

PROJECT NO. 10	
Project Name, Location and Owner's contact information:	**Description of Services Provided:**
Length of Services Provided:	**Cost of Services Provided:**

General Professional Services Questionnaire

L. List all prior and/or on-going litigation between Firm and Jefferson Parish. Please attach additional pages if necessary.

Parties:		Status/Result of Case:
Plaintiff:	**Defendant:**	
1.		Please refer to our most recent quarterly (10-Q) and annual (10-K) financial and business reports filed with the Securities and Exchange Commission (SEC) for recent and pending litigation that Humana deems material for disclosure purposes.
2.		
3.		
4.		

M. Use this space to provide any additional information or description of resources supporting Firm's qualifications for the proposed project.

N. To the best of my knowledge, the foregoing is an accurate statement of facts.

Signature: _____ **Print Name:** Steven McCulley

Title: Senior Vice President, Medicare Administration **Date:** August 18, 2022

ATTACHMENT B

INSURANCE REQUIREMENTS AND INDEMNIFICATION

H

Attachment B, Insurance Requirements and Indemnity

For Group Medicare plans, Managed Care Indemnity, Inc. (MCII) provides General Liability, Professional Liability, Errors & Omission, and Malpractice for Humana Inc. and all of our subsidiaries. This policy is written with a $3 million limit on an occurrence form with no deductible.

Humana Inc. and all of our subsidiaries are covered by a blanket Fidelity policy with National Union Insurance with limits of $15 million and a $1 million deductible, which is written on an occurrence basis.

The coverages listed above are for the offering companies listed below and do not extend to Jefferson Parish.

- Humana Health Benefit Plan of Louisiana, Inc.
- Humana Insurance Company

Deviations

INDEMNITY
To the fullest extent permitted by law, Proposer, agrees to protect, defend, indemnify and save the Parish, its agents, officials, employees, volunteers or any firm, company, organization, or individual, or their Proposers, or subcontractors with whom the Parish may be contracted harmless from and against any and all claims, demands, actions, and causes of action of every kind and character including but not limited to claims based on negligence, strict liability, and absolute liability which may arise in favor of any person or persons on account of illness, disease, loss of property, services, wages, death or personal injuries resulting from acts or omissions of Proposer, its agents, employees, assigns, or subcontractors, during the operations contemplated by the contract.

This indemnity does not extend to the sole negligence of the Parish and the Proposer shall not be liable to the Parish for its lost profits or revenue or consequential damages except claims advanced in tort and/or claims advanced in contract due to the bad faith of Proposer. Bad faith shall mean a breach of some motive or interest of ill will on the part of the Proposer.

Further, Proposer hereby agrees to indemnify the Parish for all reasonable expenses including but not limited to all fees and charges of attorneys and other professionals and all court or other dispute resolution costs incurred by or imposed upon the Parish in connection therewith for any such loss, damage, injury or other casualty. Proposer further agrees to pay all reasonable expenses and attorneys' fees incurred by the Parish in establishing the right to indemnity pursuant to the provisions in this agreement."

Humana agrees to indemnify and hold Jefferson Parish harmless from and against damages, claims, or liabilities that arise as a result of acts or omissions on our part or the part of our employees in the performance of the contract.

Our contracts do not include a hold harmless provision that indemnifies Jefferson Parish for general legal action from members, employees, subcontractors, or other vendors. We do not indemnify Jefferson Parish as a result of the acts or omissions of third parties, including its members' service providers.

ATTACHMENT B

INDEMNITY

To the fullest extent permitted by law, Proposer, agrees to protect, defend, indemnify and save the Parish, its agents, officials, employees, volunteers or any firm, company, organization, or individual, or their Proposers, or subcontractors with whom the Parish may be contracted harmless from and against any and all claims, demands, actions, and causes of action of every kind and character including but not limited to claims based on negligence, strict liability, and absolute liability which may arise in favor of any person or persons on account of illness, disease, loss of property, services, wages, death or personal injuries resulting from acts or omissions of Proposer, its agents, employees, assigns, or subcontractors, during the operations contemplated by the contract.

This indemnity does not extend to the sole negligence of the Parish and the Proposer shall not be liable to the Parish for its lost profits or revenue or consequential damages except claims advanced in tort and/or claims advanced in contract due to the bad faith of Proposer. Bad faith shall mean a breach of some motive or interest of ill will on the part of the Proposer.

Further, Proposer hereby agrees to indemnify the Parish for all reasonable expenses including but not limited to all fees and charges of attorneys and other professionals and all court or other dispute resolution costs incurred by or imposed upon the Parish in connection therewith for any such loss, damage, injury or other casualty. Proposer further agrees to pay all reasonable expenses and attorneys' fees incurred by the Parish in establishing the right to indemnity pursuant to the provisions in this agreement."

The insurance requirements shall be as follows:

All insurance requirements shall conform to Jefferson Parish Resolution No. 113646 dated 12/09/2009.
The proposer shall not commence work under this contract until it has obtained all insurance and complied with the insurance requirements of the specifications and Resolution No. 113646.

WORKER'S COMPENSATION INSURANCE
As required by Louisiana State Statute, except Employer's Liability, Section B shall be $1,000,000 per occurrence when Work is to be over water and involves maritime exposures to cover all employees not covered under the State Worker's Compensation Act; otherwise, this limit shall be no less than $500,000 per occurrence.

COMMERCIAL GENERAL LIABILITY
Shall provide limits not less than the following: $1,000,000.00 Combined Single Limit per Occurrence for bodily injury and property damage.

COMPREHENSIVE AUTOMOBILE LIABILITY
Bodily injury liability $1,000,000.00 each person; $1,000,000.00 each occurrence. Property Damage Liability $1,000,000.00 each occurrence.
DEDUCTIBLES

No insurance required shall include a deductible greater than $10,000.00. The cost of the deductible is borne by the Proposer.

PROFESSIONAL LIABILITY
Shall provide Combined Single Limit of $1,000,000.00 per Occurrence.

UMBRELLA LIABILITY COVERAGE
An umbrella policy or excess may be used to meet minimum requirements.

SUBCONTRACTOR INSURANCE
The Proposer shall include all subcontractors as insured's under its policies or shall insure that all subcontractors satisfy the same insurance requirements stated herein for the Proposer.

ATTACHMENT C

PROPOSED RATE FORM

ATTACHMENT C

Proposed Rate Form

JPG wishes to maintain the following:

Medicare Advantage	
Retiree	**PPO – Total Population: $160.98** **HMO with PPO wrap: $139.77**
Spouse/Dependent	**PPO – Total Population: $160.98** **HMO with PPO wrap: $139.77**

Please refer to our rate sheets on the following pages.

Humana Group Medicare Advantage

Humana Medicare Employer Plan – Premium Information

JEFFERSON PARISH GOVERNMENT - PPO - TOTAL POPULATION

Date: 8/17/2022
Humana Medicare Employer Plan
Plan Names: Passive PPO Custom Medical with Standard Rx1
Passive Waiver Custom Medical with Standard Rx1
Rx Formulary: Group Plus Formulary - 23800
Additional Services Included: Dental, Hearing, Vision

Plan Year	Final Billed Premium (Per Member Per Month)
1/1/2023 - 12/31/2023	$160.98

Passive PPO Custom Medical and Rx Benefit Custom Overview

	(In-Network Benefits match Out-of-Network Benefits)
Deductible	None
Inpatient Acute Hospital	$150 Copayment (days 1-5)
Skilled Nursing Facility	$25 Copayment (days 21-100)
Physician Office Visits	$5 Copayment
Specialist Office Visits	$20 Copayment
Outpatient Surgical	$100 Copayment
Ambulance	$50 Copayment
Emergency Room	$65 Copayment
Medical Maximum Out of Pocket	$2,500 Combined (Medicare Covered Services)
Prescription Drugs (Retail 30 day supply)	Rx1 $10/$20/$40/25% from $0 to Catastrophic

See attached sheet for rating assumptions and stipulations. The benefits presented above are a high-level summary. Please consult the Plan Design Exhibit for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.

Humana Group Medicare Advantage

Humana Medicare Employer Plan – Rating Assumptions and Stipulations

JEFFERSON PARISH GOVERNMENT

Proposal Terms

The benefits presented on the previous page are a high-level summary. Please consult the Plan Design Exhibit for a more detailed outline of the benefits proposed. Final benefits may differ due to annual changes in CMS benefit requirements.

For members with End Stage Renal Disease (ESRD), the Humana Group Medicare Advantage Plan is only offered to eligible members who are diagnosed and enrolled in a manner that is consistent with applicable Medicare secondary laws, and the rules and regulations set forth by CMS.

The rates provided do not reflect any potential premium adjustments provided by Center for Medicare and Medicaid Services (CMS) or federal regulations based on a Medicare beneficiary's income.

Humana will hold the proposed rate(s) unless there are material changes to existing or implementation of new federal regulations or requirements, and/or any unforeseen/unusual circumstances (i.e. pandemic) that would impact Group Medicare.

Humana will hold the proposed rates, assuming all of the information provided is accurate, and could be subject to change should any of the following differ:

All members are retired and enrolled in Medicare Part A and/or Part B.

A minimum average employer contribution level of 26% of the proposed premium for the plan.

A majority of members' (51% or more) primary residence is in an adequate Humana Medicare Advantage network service area. Humana will monitor network adequacy throughout the year to confirm standards are met.

Part D, administered by Humana Pharmacy Solutions, will utilize Humana's Group Plus formulary and include utilization management programs such as: quantity limits, prior authorization, and step therapy. Humana continually updates its drug list and quantity limits, and ensures these updates are in accordance with CMS regulations.

Benefits, deductibles, maximum out of pocket accumulators, and any applicable pharmacy TrOOP accumulators will be reset on January 1 each year.

Humana's Medicare Advantage plan can be offered alongside another carrier(s), however, there should be no additional secondary plan wrapping around or offered in conjunction with this plan for all current and future Medicare eligible retirees. Humana will hold the proposed rates assuming there are no material changes in the final plan selection and employer contribution, and number of competing plans offered to the group.

We are pleased to present this Humana Group Medicare Advantage proposal to you and assume all information provided is accurate with the understanding if there is a material change from the current offering environment, Humana has the right to revise or rescind the quote.

Humana Group Medicare Advantage

Humana Medicare Employer Plan – Premium Information

JEFFERSON PARISH GOVERNMENT - HMO

Date: 8/17/2022
Plan Names: Humana Medicare Employer Plan HMO 076 256 with Standard Rx1
Rx Formulary: Group Plus Formulary - 23800
Additional Services Included: Dental, Hearing, Vision, OTC

Plan Year	Final Billed Premium (Per Member Per Month)
1/1/2023 - 12/31/2023	$139.77

HMO 076 256 Medical and Rx Benefit Overview

Deductible	None
Inpatient Acute Hospital	$150 Copayment (Days 1-5)
Skilled Nursing Facility	$25 Copayment (Days 21-100)
Physician Office Visits	$5 Copayment
Specialist Office Visits	$20 Copayment
Outpatient Surgical	$100 Copayment
Ambulance	$50 Copayment
Emergency Room	$65 Copayment
Medical Maximum Out of Pocket	$2,500 (Medicare Covered Services)
Prescription Drugs (Retail 30 day supply)	Rx1 $10/$20/$40/25% from $0 to Catastrophic

See attached sheet for rating assumptions and stipulations. The benefits presented above are a high-level summary. Please consult the Plan Design Exhibit for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.

Humana Group Medicare Advantage

Humana Medicare Employer Plan – Premium Information

JEFFERSON PARISH GOVERNMENT - PPO - HMO WRAP (OUT OF NETWORK MEMBERS ONLY)

Date: 8/17/2022
Humana Medicare Employer Plan
Plan Names: Passive PPO Custom Medical with Standard Rx1
Passive Waiver Custom Medical with Standard Rx1
Rx Formulary: Group Plus Formulary - 23800
Additional Services Included: Dental, Hearing, Vision

Plan Year	Final Billed Premium (Per Member Per Month)
1/1/2023 - 12/31/2023	$139.77

Passive PPO Custom Medical and Rx Benefit Custom Overview

	(In-Network Benefits match Out-of-Network Benefits)
Deductible	None
Inpatient Acute Hospital	$150 Copayment (days 1-5)
Skilled Nursing Facility	$25 Copayment (days 21-100)
Physician Office Visits	$5 Copayment
Specialist Office Visits	$20 Copayment
Outpatient Surgical	$100 Copayment
Ambulance	$50 Copayment
Emergency Room	$65 Copayment
Medical Maximum Out of Pocket	$2,500 Combined (Medicare Covered Services)
Prescription Drugs (Retail 30 day supply)	Rx1 $10/$20/$40/25% from $0 to Catastrophic

See attached sheet for rating assumptions and stipulations. The benefits presented above are a high-level summary. Please consult the Plan Design Exhibit for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.

Humana Group Medicare Advantage

Humana Medicare Employer Plan – Rating Assumptions and Stipulations

JEFFERSON PARISH GOVERNMENT

Proposal Terms

The benefits presented on the previous page are a high-level summary. Please consult the Plan Design Exhibit for a more detailed outline of the benefits proposed. Final benefits may differ due to annual changes in CMS benefit requirements.

For members with End Stage Renal Disease (ESRD), the Humana Group Medicare Advantage Plan is only offered to eligible members who are diagnosed and enrolled in a manner that is consistent with applicable Medicare secondary laws, and the rules and regulations set forth by CMS.

The rates provided do not reflect any potential premium adjustments provided by Center for Medicare and Medicaid Services (CMS) or federal regulations based on a Medicare beneficiary's income.

Humana will hold the proposed rate(s) unless there are material changes to existing or implementation of new federal regulations or requirements, and/or any unforeseen/unusual circumstances (i.e. pandemic) that would impact Group Medicare.

Humana will hold the proposed rates, assuming all of the information provided is accurate, and could be subject to change should any of the following differ:

All members are retired and enrolled in Medicare Part A and/or Part B.

A minimum average employer contribution level of 26% of the proposed premium for the plan.

A majority of members' (51% or more) primary residence is in an adequate Humana Medicare Advantage network service area. Humana will monitor network adequacy throughout the year to confirm standards are met.

Part D, administered by Humana Pharmacy Solutions, will utilize Humana's Group Plus formulary and include utilization management programs such as: quantity limits, prior authorization, and step therapy. Humana continually updates its drug list and quantity limits, and ensures these updates are in accordance with CMS regulations.

Benefits, deductibles, maximum out of pocket accumulators, and any applicable pharmacy TrOOP accumulators will be reset on January 1 each year.

Humana's Medicare Advantage plan can be offered alongside another carrier(s), however, there should be no additional secondary plan wrapping around or offered in conjunction with this plan for all current and future Medicare eligible retirees. Humana will hold the proposed rates assuming there are no material changes in the final plan selection and employer contribution, and number of competing plans offered to the group.

Pricing assumes that all members residing in an HMO service area must enroll in the HMO plan. Only members outside of the HMO service area are eligible to enroll in the PPO plan.

We are pleased to present this Humana Group Medicare Advantage proposal to you and assume all information provided is accurate with the understanding if there is a material change from the current offering environment, Humana has the right to revise or rescind the quote.

ATTACHMENT D

CARRIER QUESTIONNAIRE

Attachment D, Carrier Questionnaire

1. **Name and address of parent company and local office.**

   Humana
   500 West Main Street
   Louisville, Kentucky 40202

   In Louisiana we have 789 Humana associates, and 718 associates work out of our Metairie locations.

   Our locations:
   Humana
   One Galleria Boulevard, Suite 1200
   Metairie, Louisiana 70001

   Humana Marketpoint Office
   8814 Veterans Boulevard
   Metairie, Louisiana 70003

   Humana Neighborhood Center
   747 Veterans Boulevard
   Metairie, Louisiana 70005

2. **Is your company a wholly-owned subsidiary or a division of another company? If so, please identify the company name and address.**

   CareNetwork, Inc., a Wisconsin general business corporation, owns 100% of the issued and outstanding stock of Humana Insurance Company. CareNetwork, Inc. is a wholly owned subsidiary of Humana Inc., the ultimate parent in the holding company system.

3. **How many members are being served by your company nationally and in Louisiana?**

State	Individual MA	Group MA	Total Medicare Advantage	Stand-alone PDP	Total Medicare	Medicare Supplement
Nationally	4,277,517	609,654	4,539,168	3,461,362	8,000,530	317,400
Louisiana	207,700	14,300	222,000	50,800	272,800	4,000

How many employers with over 1,000 retirees are currently being served?

Humana is currently servicing 40 groups with over 1,000 members nationwide. We have a total of 43 Group Medicare employer groups in Louisiana, with three groups in the State with over 1,000 employees and three additional groups with over 1,000 Medicare retirees where we offer more than one option to the retirees.

4. **Provide three references that have similar dynamics to Jefferson Parish Government. At least one reference group should have gone through the respective enrollment process within the last two years. Include contact names, phone numbers and email addresses.**

   Confirmed. The following clients have agreed to serve as references for Humana.

   City of Newport News
   Brian Sypolt
   sypoltbj@nnva.gov
   757-926-8499

   Gwinnett County Government
   Karissa Ogburn
   Karissa.ogburn@gwinnettcounty.com
   770-822-7912

   Lafourche Parish School Board
   Chastity Himel
   chimel@mylpsd.com
   985-435-4658

5. **How long has your company been in business?**

   Humana has been in business more than 60 years. Founded on August 18, 1961 by David Jones and Wendell Cherry, Humana started as a nursing home business, and later moved into the hospital business and, by 1980, had become the world's largest investor-owned hospital company. In 1983, we entered the medical insurance business and launched a health maintenance organization (HMO) designed to help employers control premium costs while at the same time providing better patient care coordination.

   In 1993, we spun off our hospital division as a separate publicly held corporation and then shifted our focus solely to health insurance products. Through the 1990s and early 2000s, we expanded our insurance product lines to encompass a broad continuum of member segments (e.g., individual insurance, Medicare, Medicaid, TRICARE, etc.) and a full line of specialty insurance products (e.g., dental, vision, life, STD/LTD, worksite voluntary, etc.).

   Medicare is a significant part of Humana's business and a major contributor to our success. We offered our first private Medicare plans in 1985 and our first Medicare plans for employers in 1990. Since then, we have continuously provided the stability, depth of expertise, infrastructure, and sophistication to meet all our Medicare members' needs:

   - **1997**: After key provisions of the Balanced Budget Act of 1997 severely cut private plan reimbursements and caused most major carriers to exit numerous markets, we were one of the few major carriers to maintain a strong private plan commitment to Medicare. Throughout, we continued to maintain and improve our Medicare plan infrastructure and to foster the growth of our membership.

- **2003**: With the passage of the Medicare Modernization Act in 2003, which introduced Part D coverage and renamed the plans to "Medicare Advantage," we developed and executed an aggressive plan to expand both our Medicare product lines and service areas.
- **2007**: We implemented Medicare Prescription Drug Plans (PDP) and Medicare Advantage Private-Fee-for-Service (PFFS) plans throughout the United States and Puerto Rico, Regional PPO plans in 23 states, and Local PPO plans in many of these same states and several others and Puerto Rico. We also embarked on a plan to expand our HMO offerings from our core markets in Florida and several other states to many additional areas in those and other states. Today, we offer our Medicare plans to employers in all 50 states and Puerto Rico, as well as our HMO plans in dozens of markets nationally and Puerto Rico, with plans to continue to expand both PPO and HMO products in many additional areas, including new states.

In terms of membership, Humana has always been one of the largest Medicare carriers. In 2005, we had approximately 560,000 Medicare members. With the start of PDPs and the full-fledged introduction of PFFS and Regional PPO plans in 2006, our membership grew to more than 3.5 million members. Our total Medicare membership now stands at over 8.6 million, making Humana one of the two largest Medicare and PDP carriers.

To serve the large size and geographic scope of Humana's Medicare Advantage program, we have built a large infrastructure to support our Medicare and other senior products. As of today, our Senior Products Division has nearly 14,000 associates engaged in supporting every aspect of Medicare plan operations: product development, sales, compliance, enrollment, claims processing, and member services.

6. What is your A.M. Best rating? If applicable.

	A.M. Best
Humana Insurance Company	A-
Humana Health Benefit Plan of Louisiana, Inc.	A1

7. What is the size of your local staff?

Erin Dey, your senior account executive, manages the Parish's account locally from Louisiana.

Humana has several locations in Jefferson Parish. Our largest number of employees work from the Galleria in Metairie. The staff at the Galleria consists of teams that include Provider Customer Service, Clinical Intake team, Nurse Case Managers, Medical Directors, Finance, and Administrative Support in addition to sales teams. We also have a Metairie office that employs a wide array of individual Medicare sales, and we are proud to have a Neighborhood Center in Metairie that is open not only to Humana Medicare Advantage members, but to the community as a whole. In Louisiana we have 789 Humana associates, and 718 associates work out of our Metairie locations. Humana's Metairie Neighborhood Center, in addition to providing social activities, exercise classes, and weekly healthy cooking demonstrations, also has an onsite Customer Service representative available to assist members face-to-face.

Our locations:
Humana
One Galleria Boulevard, Suite 1200
Metairie, Louisiana 70001

Humana Marketpoint Office
8814 Veterans Boulevard
Metairie, Louisiana 70003

Humana Neighborhood Center
747 Veterans Boulevard
Metairie, Louisiana 70005

8. **Provide a resume for each key employee in your organization who will be handling the account**

   Please refer to Attachment D for the Account Management team resumes.

9. **List three references of over 1,000 retirees' who you administer the health plan. Please provide employer, contact, address and phone number of references**

   City of Newport News
   Brian Sypolt
   sypoltbj@nnva.gov
   757-926-8499

   Gwinnett County Government
   Karissa Ogburn
   Karissa.ogburn@gwinnettcounty.com
   770-822-7912

   Lafourche Parish School Board
   Chastity Himel
   chimel@mylpsd.com
   985-435-4658

10. **Describe the account management services and the team that would be responsible for handling the Parish account.**

    As an incumbent, the Group Medicare Account Management team currently in place would continue to service Jefferson Parish in conjunction with Humana's Commercial Account Management team.

    To ensure a collaborative and mutually agreeable implementation/renewal, our experienced Account Management team partners with Jefferson Parish from the beginning. Your current Group Medicare senior account executive, Erin Dey, has 17 years of experience at Humana in Medicare Advantage and uses a project management approach that properly aligns substantial resources around your specific needs.

We use a number of best practices learned through our decades of extensive experience with implementations/renewals, as well as our close collaborative relationship with CMS, to ensure a smooth and successful transition/renewal for Jefferson Parish and your retirees. These practices have helped bolster effective implementations/renewals for all our state and governmental entities ranging in enrollment numbers from 2,000 to over 63,000, including several large state health plans representing in excess of 200,000 retirees.

Account Management Team

For large, public-sector clients such as Jefferson Parish, we provide Account Management and Customer Care teams comprised of experienced Humana Commercial and Group Medicare associates who manage and perform every aspect of implementing/renewal and servicing Medicare Advantage plans. Due to the nature of Medicare Advantage plans following CMS guidelines as well as the specialized support provided to Medicare retirees, Humana's teams to support Medicare retirees vs active/non-Medicare retirees are separate. Our team will collaborate with Jefferson Parish to develop a solid implementation/renewal strategy and to refine the renewal schedule we provide during the proposal process. Our implementation/renewal strategy team is responsible for:

- Implementation/renewal plan and execution
- The member experience
- The client experience
- The post-enrollment experience

This strategy and plan addresses every aspect of the implementation/renewal process, including pre-implementation and post-implementation activities, specific assignments, accountabilities, critical milestones, and tracking notes. We work with Jefferson Parish to determine the exact size and composition of our team, taking into consideration specific needs and the makeup of the business awarded to us.

Your Account Management team remains the same. We have been managing your Group Medicare plan since 2005 and look forward to continuing to service Jefferson Parish. This team has been selected from our dedicated Senior Segment, which has years of experience servicing Medicare Advantage clients. Our goal is to provide overall management of Jefferson Parish's needs, as well of those of your Medicare population. This team consists of:

- **Senior Account Executive:** Your designated senior account executive, Erin Dey, is responsible for overseeing and managing day-to-day activities pertinent to your account. Erin has been the assigned account manager for nine years. She will continue to provide consistent, quality support to Jefferson Parish staff in all areas related to the account including, but not limited to: member inquiries and requests, provider relations, member communications, and delivery of annual renewals. Erin will serve Jefferson Parish throughout the life of your relationship with Humana.
- **Account Installation Manager (AIM)** : Your designated AIM, Maisie Mitchell, will continue to serve as your single point of contact both during and after implementation/renewal. Using her years of experience in managing Medicare plans and her experience with Jefferson Parish, she serves as your ally throughout the life of your relationship with Humana. This simplifies the service experience by creating a trusted advocate to help clients by:
  - Facilitating status meetings
  - Sending Jefferson Parish the most up-to-date Group Medicare administration manual (manuals updated annually)

- Confirming benefit plans are open to pay claims prior to plan effective date
- Timely enrollment of all retirees
- Ensuring retirees receive all of the required materials (ID cards, etc.) to properly access their benefits prior to the plan effective date
- Delivering enrollment reporting as requested

- **Communications Consultant:** Jefferson Parish also has a designated communications consultant, Christah Sykes. Christah serves as a liaison between Jefferson Parish and member communications, the pre-enrollment call center, and the Group Medicare enrollment team. Christah is responsible for capturing your communications needs and providing information on timelines, processes, etc., and consulting on the overall communications strategy. She also engages with all the necessary internal partners needed for planning and implementation/renewal coordination. Christah ensures your members have access to:
  - Educational materials
  - Enrollment seminars
  - Enrollment call center for guidance

Jefferson Parish also receives executive sponsor support from the president of Humana's Senior Products. They are responsible for operational leadership of our Medicare HMO and PPO health plans, Medicare prescription drug plans, Medicare supplement policies, and private fee-for-service health plans offered to people eligible for Medicare within their assigned region. They will collaborate closely with Jefferson Parish on network, clinical, and market strategies.

The proposed Account Management team for Jefferson Parish includes the following:

- Carla Whaley, Associate Vice President, Account Management, Executive Sponsor
- Tiffany Calderon, Director of Account Management, Group Medicare
- Erin Dey, Senior Account Executive, Group Medicare
- Maisie Mitchell, AIM
- Christah Sykes, Group Medicare Communications Consultant
- Courtney Bell, Account Concierge Specialist
- Annie Eckert, Enrollment Analyst

Please refer to Attachment D for our Group Medicare account team resumes.

11. Describe the support you would provide as part of a change in vendors. Provide an implementation and communication schedule showing tasks, allocation of responsibilities and personnel.

Humana's implementation/renewal process is structured to ensure we deliver Jefferson Parish's employees a seamless, uninterrupted transition to their new medical plan(s). Erin Dey, the current Medicare Advantage account manager, will ensure this transition is managed appropriately due to her experience working with the Parish as well as new implementations and spearheading project management during renewal.

Pre-Implementation

Your AIM, Maisie, leads a collaborative implementation/renewal strategy by meeting with your benefit administrators and the appropriate Humana associates to discuss key implementation/renewal issues and critical milestones. During this meeting, administration details — including enrollment, eligibility,

billing, and retiree communications—are set and a draft implementation/renewal timeline is developed to share, review, and revise throughout the implementation process.

Please refer to Attachment E for a sample implementation/renewal timeline.

Implementation/Renewal/Pre-Enrollment
During implementation/renewal, a custom benefit overview meeting is conducted with Jefferson Parish where all parties are allowed a chance to review and amend the benefit plan designs and processes as necessary before they are built into our systems. Once these components are settled, we coordinate with our Benefit Load and Plan Set-up departments to create group numbers for Jefferson Parish. To ensure the account set-up is correct and the benefits are loaded properly, our Account Auditing team conducts a quality review.

Enrollment
Jefferson Parish can elect to have all retirees complete a paper, or telephonic, application. Paper applications can be mailed to all eligible retirees and their spouses. Applications are normally sent back directly to Humana for processing. We also have the option to setup telephonic applications for retirees. The retiree would be assisted by a licensed agent and enrolled in the plan over the phone.

Humana can also setup a reoccurring eligibility file sent via secure FTP. The details of such a file will be discussed during implementation/renewal to establish the layout and timing.

The most common option is a combination of a one-time spreadsheet and EDI file. Each member must have an accurate name, Medicare ID, DOB, gender, and residential address (there are two address fields for members that have a PO Box and a residential address) included on the spreadsheet. The one-time spreadsheet can be used for transitioning current Medicare Advantage members on non-Humana plans for the January 1 enrollment. When utilizing the spreadsheet enrollment option, members must receive their enrollment kit at least 21 days prior to effective date.

For all enrollment methods, enrollment must be received prior to the requested effective date.

Implementation/Renewal/Post-Enrollment
Maisie reviews your EOC and any specialized language. Our Compliance, Contracts, and Product Design teams provide guidance and verify that the final EOC meets your approval. Once we receive and load the enrollment file, Maisie initiates the enrollment audit and ID card process. Then the ID cards are ordered, a live ID card is reviewed, and a final approval is required before the cards are shipped to annuitants.

Post-Implementation
A confirmation letter of enrollment letter is mailed within seven to 10 days of a member's enrollment. Members can then expect to see an ID card in their mailbox within three weeks after enrollment. Based on CMS' requirements, all members will receive an EOC. This is sent within 30 days of the member's effective date. Humana will also mail all members a health assessment survey in their first month of enrollment. The health assessment is used to determine if the member may qualify for any care management programs we offer as well as help the member to understand their current health state and needs. This outreach also helps support Stars initiatives and satisfy important CMS regulations.

Once implementation/renewal is complete, Erin and Maisie meet with you to discuss any outstanding concerns. After these wrap-up meetings, both Erin and Maisie remain your points of contact for all ongoing support questions. Your assigned ACS, Courtney Bell, also works directly with the Account Management team to identify and resolve escalated client issues. Identified issues are shared with Customer Care specialists.

Retiree Experience
Operational aspects of implementation/renewal are performed by our dedicated Group Medicare Operations unit, who works hand-in-hand with the Account Management team and is assisted by local Humana associates in our clinical and network areas both during and after implementation/renewal. This Operations unit grows as our Group Medicare business continues to grow, and is comprised of the top operations associates in our Medicare business. These associates are selected from the vast staff of our individual Medicare Advantage and PDP business, which provides a superb training ground for our Group Medicare associates.

Group Medicare members have a dedicated Group Medicare Customer Care unit completely focused on working with Medicare Advantage plans and serving retirees and their families. All associates in this unit undergo intense training to become knowledgeable in the benefits and dynamics specific to Jefferson Parish prior to joining this team.

Furthermore, these associates have access to the most up-to-date customer information. During implementation/renewal, the Account Management team collaborates with Jefferson Parish to create a detailed document for the Customer Care specialists serving the account containing all benefit information, hot topics, and any pertinent information. This document is referenced during all member calls.

12. Do you agree to comply with all of the proposal assumptions and requirements as outlined in this SOQ? If not, specifically explain how your proposal deviates from this.

Humana agrees to indemnify and hold Jefferson Parish harmless from and against damages, claims, or liabilities that arise as a result of acts or omissions on our part or the part of our employees in the performance of the contract.

Our contracts do not include a hold harmless provision that indemnifies Jefferson Parish for general legal action from members, employees, subcontractors, or other vendors. We do not indemnify Jefferson Parish as a result of the acts or omissions of third parties, including its members' service providers.

13. Do you agree to administer the requested benefits plan as described? If not, specifically identify any variations in plan designs.

Confirmed. Humana is offering a passive PPO plan design (allows the same benefit both in and out of network, as long as the non-participating provider is willing to accept the member and send the bill to Humana). We are also offering an alternate option for consideration by the parish. The second option leaves the HMO in place and offers a PPO wrap around the HMO where the HMO is not available.

14. Describe your enrollment process.

Humana's Group Medicare enrollment processes operate separately from those in the Individual Medicare space. Enrollment files and transmission activities are aligned based on Jefferson Parish's Open Enrollment dates and CMS guidelines. As best practice, Humana recommends the first enrollment file be submitted 30 to 45 days prior to the plan effective date. The timing allows for testing of data file integrity prior to moving to production. Additionally, it allows time to manually resolve incomplete or pending enrollments that may not process first pass.

Humana processes EDI files based on time of receipt, with a processing schedule running up to six times per day, seven days a week. Once the file is loaded in the system, enrollments without errors are sent to CMS within two days. We normally receive acceptance for error-free enrollments within two days of receipt from CMS. If any enrollment records require manual review, we extend the review process before submitting the enrollment request to CMS. Member enrollment requests are sent within seven days of receiving the EDI file, with the exception of retirees asked to correct missing or incorrect information.

15. What is your administration charge as a percentage of premiums for JPG?

This is not applicable to Group Medicare Advantage plans.

16. What is the JPG pooling level and estimated pooling charge for 2021?

This is not applicable to Group Medicare Advantage plans.

17. What unique services or support does your organization provide that you believe sets you apart from your competition?

With over 29 years of Medicare experience and a deep working relationship with CMS, we are considered pioneers in the industry. This also comes with many more years of experience working with active employer group solutions. Humana is deeply entrenched in Louisiana with over 700 employees working from our Metairie location.

In support of our senior population, Humana has the most robust wellness and rewards program of any carrier.

We are also very happy to support Jefferson Parish by having a Neighborhood Center in Jefferson Parish, along with other neighborhood locations in Louisiana and throughout the United States. Our Neighborhood Centers provide the opportunity for not only Humana members, but residents of Jefferson Parish as whole to engage in social and physical activities to help improve the overall wellbeing of the community. Some of the activities include weekly healthy cooking live demonstrations with food tasting, bridge groups as well as other card groups, crafts, movie days, and so much more, as well as always having a fresh cup of coffee available and a healthy snack and people to have a conversation with. For Humana members, we also offer several opportunities for Silver Sneakers exercise each week. Since the pandemic, we have also expanded our outreach to virtual neighborhood center activity.

Please refer to Attachment F, Sample Neighborhood Center Virtual calendar.

Our Neighborhood centers in Metairie and Baton Rouge also have a Customer Service representative available for members who want to speak with someone in person.

Humana's differentiating core competencies include the uniqueness of our business model: a consumer health-focused, integrated care model, oriented toward seniors. To that end, we will continue to enrich our differentiated Human Care model by focusing on the following key priorities:

- **Increasing our local presence through value-based primary care access.** Today we operate 189 owned/path-to-owned practices and have established 173 alliance partnerships with innovative provider partners. This number is expected to grow to 673 clinic locations by 2024. In addition, Humana's CenterWell Senior Primary Care, a wholly-owned subsidiary of Humana, is our newest primary care medical group practice. CenterWell has a strong emphasis on senior-focused primary care for members of Medicare Advantage health plans and is committed to providing personalized, high-quality primary care combined with an excellent patient experience. Humana wants to provide access where our members want to receive care. Communities are in need of senior-focused primary care, and we believe that providing local access to full service primary care, pharmacy, nutrition, behavioral health, wellness support, social work and other services will help senior spend less time in the hospital and other institutional settings. CenterWell has seven Louisiana locations: Hammond, Slidell, Denham Springs, Bossier City, Lafayette, Shreveport, and Covington.
- **Expanding our focus on providing value-based care in the home.** This is evident in our investment in Kindred Home Health where we are reengineering the handoff from inpatient to home-based care. In addition, our recent partnerships with Heal and Dispatch Health will allow us to perform more complex services in the home along with investments in advanced end-of-life care and hospice support.
- **Advancing our digital and analytics infrastructure** including cloud migration, interoperability, and the creation of a longitudinal health record to elevate the experience, service, and quality of care our customers expect from us.

Finally, one of our greatest contributions to the New Orleans area is Humana's Bold Goal:

Bold Goal in the Greater New Orleans - Orleans and Jefferson Parishes
Humana's Bold Goal is to improve the health of the people and communities we serve by making it easy for people to achieve their best health. We address whole-person health, and particularly Health-Related Social Needs, by co-creating solutions that seamlessly integrate clinical and social aspects of care. Through our Bold Goal, we are collaborating with nonprofit organizations, businesses, government leaders, and healthcare professionals. We are working to identify the root causes of poor health and build a stronger healthcare ecosystem that meets people where they are on their health and well-being journey.

Developing a Sustainable Infrastructure
Our Bold Goal strategy is focused on the creation of a sustainable infrastructure, integrating health related social needs (HRSNs) into our clinical, home health and pharmacy capabilities – allowing physicians, clinicians and Humana care teams to address and impact an individual's whole-person health. As part of our clinical model, we developed and made tools available to support primary care physicians/clinicians, helping them screen and solve for food insecurity, social isolation, and loneliness.

To further this work at the community level, we developed clinical partnerships with Ochsner Health, JenCare, Second Harvest Food Bank, March of Dimes (Maternal Health Equity), to advance population health, address social needs, and focus on co-creating initiatives to improve the health of individuals.

Addressing Health Related Social Needs

We address whole-person health, and particularly Health-Related Social Needs, by co-creating solutions that seamlessly integrate clinical and social aspects of care. We recently launched the Humana findhelp platform. It is a social health access referral platform; Humana's white-labeled site, powered by findhelp. This is an active directory of resources across the United States that address the social needs of our members. Resources are shared via an online platform to enable finding and connecting to these resources. All programs listed are direct services that are free, reduced or sliding scale cost.

Fostering Partnerships in Greater New Orleans Region

Humana collaborates with the Greater New Orleans Region, which includes Jefferson Parish and local community-based organizations to address social determinants of health (SDOH) and develop direct interventions to support its senior population and the most vulnerable. These community health linkages offer tools and resources to identify and address SDOH and connect those in need to resources, while simultaneously supporting the community-based organizations providing services. Examples include:

- As part of the Greater New Orleans Bold Goal, including Jefferson Parish, we are using education and awareness to help improve health outcomes of the citizens in our community, economic challenges that include the lack of access to healthy food, shortage of affordable housing, inadequate education and limited workforce opportunities.
- Humana is focused on creating solutions that address disparities for more equitable care and health outcomes. With more than $16 million in community investments since 2019, and investments in March of Dimes partnership to impact moms and babies.
- As a top priority to provide access to behavioral health services in rural Louisiana, Humana continues to lead conversations with partner organizations, like National Alliance of Mental Illness (NAMI), to address the stigma associated with needing and seeking services.
- Other strategies for targeted interventions that improve health quality and outcomes in Louisiana include identifying and addressing key SDOH.

Enabling Interventions

Humana is in a unique position to support key social needs like food, social support and transportation through health plan benefit, community health linkages, and services that address the whole-health needs of individual members. Humana leverages strong coordination and partnership to address health equity and SDOH in communities across the country. Responding to the needs of the community reveals that Humana is more than a health plan but a partner in human care for the state of Louisiana.

18. Please provide results from the following surveys for 2020/2021:

- **Member Satisfaction**

  We have achieved a +79 Net Promoter Score (NPS) for Group Medicare Clients, which is considered best-in-class and have been awarded #1 in customer service by Newsweek among all health insurance companies for two years in a row.

Humana's goal is to provide best-in-class customer service. To ensure every component of our Medicare Advantage program is providing outstanding performance and customer service, we measure satisfaction through various levels of member interactions. This includes internal performance surveys of our dedicated Group Medicare claims and customer service areas, clinical programs, and Care Management services; client-specific surveys for larger customers; and extensive quality and customer service surveys included in the CMS 5-Star Quality Rating program. Below is a detailed description of each measurement level.

Internal Performance and External Customer Service Surveys, Measures, and Use
Our dedicated Group Medicare Customer Care unit leverages Genesys as our quality monitoring system. This system records 100% of inbound service calls and 100% of all desktop screen activity for each associate. Recorded calls are stored in a centralized cloud with full failover and disaster recovery. This, coupled with our internal quality evaluation system, Alliance, allows us to measure performance on an individual associate and business segment level. These systems incorporate a wide array of tools to develop and administer call quality methodologies consistent with our service strategy. Our quality strategy focuses on accuracy, reducing costs and associate friction points through quality monitoring, and turning business level insights into action.

Each associate receives five evaluations per month from call quality auditors, coupled with member surveys to provide a comprehensive performance view both internally view and from the client. These evaluations are shared with associates immediately following the completion of each evaluation. Supervisors utilize this evaluation performance data to help associates reach and sustain the exceptional service levels for all frontline associates. Our quality standard is to meet 95% accuracy and satisfaction, which we continuously exceed. Approximately 15 to 20% of Customer Care specialists also receive additional focused coaching and development from Call Quality team members in addition to the interactions that occur with their frontline leaders.

From an external member perspective, Humana conducts and receives member satisfaction surveys daily. We conduct transactional member satisfaction surveys through our Voice of the Customer (VOC) program. Effective January 1, 2022, Humana's VOC surveys are administered by vendor InMoment, a best-in-class omni-channel customer experience feedback platform that delivers high quality insights to inform decisions leading to improved customer engagement and retention. This state-of-the-art platform uses dynamic, adaptive AI technology with real-time VOC reporting where users can easily aggregate data for holistic storytelling and reporting.

The automated survey asks the caller questions about their overall experience with Humana and the quality of their recent experience. The survey permits the caller to leave a recorded message, which is translated into written text and housed in InMoment as a WAV file.

Surveys are offered to callers who access Humana's IVR system via the toll-free customer service phone number. Callers who request to speak to a representative are asked to participate in a short survey. The caller may elect to either opt-in or opt-out of the voluntary survey. For those who participate in the survey, the caller is asked to verify their preferred callback number before routing them to the customer service associate for assistance.

After disconnecting the call, an automated dialer contacts the caller within 30 minutes to complete the survey. Members are prompted to answer the following questions centered around three emotional pillars: ease, caring and personalization:

- How likely are you to recommend Humana to a family member or friend? (0-10 scale)
- Please share how your overall experience went. What went well and where could we make improvements?
- The representative knew how to help me (1-5 Agreement)
- It was easy to work with the representative (1-5 Agreement)
- I felt that the representative cared about me (1-5 Agreement)
- Overall, it was easy to address my needs (1-5 agreement)
- Are you confident that your inquiry or question has been or will be resolved? (Yes or No)

Through this program, we are able to capture direct member feedback which facilitates opportunity awareness, coaching, insight collection, and process improvements. Survey results are shared with Customer Care specialists in real time and used as part of their performance reviews as well as any incentive program for the specialist.

CenterWell Pharmacy achieved the No. 1 ranking for Mail Order Pharmacy customer satisfaction by J.D. Power in their 2021 U.S. Pharmacy Study. It marks the fourth year in a row that Humana Pharmacy has captured the honor.

In addition, Humana was ranked number one among health insurers for Customer Experience (CX) quality in Forrester's 2021 US CX index. The Forrester CX Index score measures how well a company delivers customer experiences that create and sustain loyalty.

Humana 2021 CX Index Press Release

Humana ranked #1 among Health Insurers nationally for three of the last four years in Forrester's Customer Experience Benchmark Survey*

- **Provider Satisfaction**

Humana conducts an annual provider feedback survey that primarily focuses on the administrative aspects of Humana's relationship with providers. The survey measures satisfaction with timeliness and accuracy of claims payment, provider education on our policies and processes, issue resolution, helpfulness of website, etc. Additionally, we may periodically survey subsets of our provider network on specific needs (e.g., utilization management). These results are considered proprietary.

We also obtain provider feedback through periodic focus groups and provider advisory groups. In these groups, we seek provider input on various proposed Humana and healthcare industry trends. We also receive feedback through ongoing relationships with organizations such as the Medical Group Management Association.

c. Benefits Manager Satisfaction

We also provide an annual client satisfaction survey to be completed by designated members of the Parish's Benefits team. The survey addresses the overall program, including service, marketing, and account management. These results are considered proprietary.

19. For which services, and to whom, do you outsource the following:

- **Mental Health**

  Mental health services are not outsourced; these services are delivered to our members from our comprehensive provider network which offers both in person and virtual appointments.

- **Laboratory**

  Laboratory services are not outsourced; Humana contracts with ancillary providers for laboratory services.

- **Vision**

  Vision services for non-Medicare covered eye exams and glasses/contacts are contracted with VSP.

- **Prescription Drug**

  These services are performed internally.

  We use Humana Pharmacy Solutions as our pharmacy benefits manager (PBM). Humana Pharmacy Solutions, a wholly-owned subsidiary of Humana, was incorporated on August 8, 2011 and has been providing PBM services since January 1, 2012. Please note, Humana Pharmacy and Humana Specialty Pharmacy were rebranded as CenterWell Pharmacy and CenterWell Specialty Pharmacy effective June 2022.

  Humana began offering pharmacy benefits in 1985 and opened our mail-order pharmacy, Humana Pharmacy® (now CenterWell Pharmacy™), in 2006 and our specialty pharmacy, Humana Specialty Pharmacy® (now CenterWell Specialty Pharmacy™), in 2009. Today, we provide pharmacy services for more than 11 million lives, process more than 430 million prescriptions annually, and manage approximately $26 billion in prescription drug spend. We employ more than 5,000 pharmacy associates, including 800 in-house pharmacists who focus solely on understanding prescription drug benefits and how they can support the member's total health. This approach helped us to grow into one of the largest PBMs in the country.

  Our pharmacy achieved the No. 1 ranking for Mail Order Pharmacy customer satisfaction by J.D. Power in their 2021 U.S. Pharmacy Study. It marks the fourth year in a row that our pharmacy has captured the honor.

  With Humana as the PBM for this offering, Jefferson Parish gains innovative expertise from a leading health insurance provider and the flexibility of a major pharmacy benefits partner.

- **Network Management**

  Humana completes network management services in-house. Humana continually manages the size and performance of our provider networks to meet the needs of MA members and clients and to control cost, quality, and member satisfaction. Critical to Humana's network management efforts is member access to care. Humana has extensive experience working collaboratively with our clients to develop and successfully execute strategies to ensure reasonable access to cost-effective care for every member.

f. Utilization Management

While case management services are provided in house, Humana uses several vendors for providing support to commercial and Group Medicare members. These clinical third-party vendors deliver services directly impacting members; however, we strive to make the services of each vendor as seamless for members as possible. Details on the service provided by each vendor are as follows:

- **Monogram Health, DCI Reach, Somatus, Healthmap Solutions, Inc., and Fresnius ESKD Risk:** late-stage chronic kidney disease (CKD) and end-stage kidney disease (ESKD)
- **HealthHelp:** Radiology Review Services, Radiation Therapy Management, Cardiac Consultation, Sleep Apnea Site of Service Optimization
- **Cohere Health and Optum Health:** Therapeutic, Musculoskeletal, and Pain Management Review
- **New Century Health and Oncology Analytics:** Oncology Quality Management*
- **HGS Healthcare & EXL Holdings:** Provide administrative cost savings by performing clinical and non-clinical support for pre- and post-service authorizations, claims, and provider disputes
- **Focus Health:** Performs peer reviews of behavioral health requests for services. Review may include requests for a patient's admission, stay or other service or course of treatment (including outpatient procedures and services). Reviews can be pre-service, concurrent, post-service, initial requests, and first and second level appeals
- **Tivity:** UM – Various levels of UM and chiropractic services depending on geographic location and line of business
- **naviHealth, Inc.:** Provides support to members admitted to a Skilled Nursing Facility (SNF)
- **myNEXUS, Inc.:** Home health UM (if offered in the member's market).
- **Aspire Health:** Provides an extra layer of physical and emotional support to members and their families throughout the course of their illness to improve their quality of life and reduce risk of hospitalizations

*Oncology Quality Management is administered by New Century Health or Oncology Analytics, depending on location.

20. What are your weekday and weekend hours of telephone services availability?

The Group Medicare Customer Care center hours of operation are from 8 a.m. to 9 p.m. Eastern time, Monday through Friday. An automated information line is available 24 hours a day, seven days a week. Extensive self-service functions are also available on our website, **Humana.com**.

Our pharmacy's customer service hours are from 8 a.m. to 11 p.m., Monday through Friday, and Saturdays from 8 a.m. to 6:30 p.m., Eastern time. The customer service line is open most holidays,

except Thanksgiving Day and Christmas Day. The facility dispensing hours are from 6 a.m. to 4:30 p.m., Monday through Friday, Eastern time. Additional shifts and/or weekend shifts are added as needed to support dispensing levels.

21. For member services, what was the 2020 or 2021 telephone average speed of answer?

a. Member Line

- 2021: 21 seconds
- 2020: 39 seconds

b. Provider Line

- 2021: 14 seconds
- 2020: 32 seconds

c. Combined

Member and provider lines are managed by different call centers. We do not typically combine these statistics.

d. Medical/Utilization Review Line

- 2021: 11.8 seconds
- 2020: 23.9 seconds

22. What is your Website address and what member information can be accessed from the Website?

Members can activate or sign in to their MyHumana account by going to **Humana.com** and clicking "Sign in."

By signing in to MyHumana, members can easily find their Humana member ID, get information on their coverage, claims and spending account information, find an in-network provider, or get reminders for care they may need to achieve their best health.

Coronavirus

- Get timely information on member benefits related to COVID-19
- Find resources for prevention, or if the member is experiencing symptoms
- See information on telehealth
- Find community resources related to basic needs

Coverage and Claims

- View coverage, benefits and plan details, including coverage and out-of-pocket responsibility
- Get information on claims and claim status, amount owed – if any, download claims and view year-to-date information
- See SmartSummary Statements and Smart EOBs
- Find information on special discounts and savings

- View accumulations on deductibles and out-of-pocket maximums (if applicable)

Health and Wellness

- Get reminders to complete screenings or other preventive health care that can help the member achieve their best health
- Find out how to use telehealth (also called virtual visits) for getting care
- Download Blue Button health data – a record of a member's PHI – including information on current conditions, prescription history, or lab history
- Access health tools for surgery planning and creating a checklist of things to talk about with their doctor
- Find information on Humana health programs
  - For members with diabetes: Get a personalized page on diabetes that displays health stats and related health improvement messages
  - (If applicable) See information on Go365, and easily navigate to the Go365 member site

Pharmacy

- Robust pharmacy information and tools help members understand what's covered, the estimated cost of a drug at retail pharmacies and mail-order, prior authorization status, drug alternatives, and drug library and drug interaction tools
- RxMentor® lets members store and keep track of their medicines and allergies all in one place. Members can populate their medication list using their previous claims and have the opportunity to edit their list, add OTC medications, and print the list to share with their doctor.
- Humana will also inform members of savings opportunities

Account Management

- Set communication preferences to inform Humana how they would like to receive communications
- Manage email address and password
- Share access to PHI with someone else; manage shared access
- Request support for accessibility needs, such as hearing impairment or visual impairment

Billing

- Make premium payments, or set up automated recurring payments
- Set or change payment method
- View billing account balance and history

Help, Support & Tools

- ID card center: view, print and order Humana member ID cards from a central location
- Find a doctor tool: easily search for in-network doctors, dentists, specialists, urgent care centers, hospitals or pharmacies. Members can search by name, specialty or condition.
- Chat with a Humana representative
- Ask Humana/Ask the Pharmacy – Search for answers to questions, take action from answer text, and see related questions
- Use the Contact us page to easily find the right phone numbers if a member needs to contact Humana

Other

- Responsive website design provides an optimized experience for various screen sizes including mobile devices and tablets
- MyHumana is also available in Spanish

Our MyHumana mobile app allows members to manage healthcare needs virtually anywhere, anytime. Accessible on any smartphone device, members can download the MyHumana app. Through our mobile app, Medicare members can:

- Access medical, pharmacy and dental ID cards
- Send their ID card to their provider through fax or save the image to their photo gallery
- Find a doctor, pharmacy, dentist, hospital, urgent care center or retail clinic. Members can use their current location to find the closest in-network provider – no matter where they are. Providers can be filtered with a set of different criteria.
- Search prescription and over-the-counter drugs and price them (must be ordered on the Humana Pharmacy app)
- Manage list of prescription and over-the-counter drugs that user is currently taking using the MyMeds flow.
- View medical, dental, and pharmacy claims
- View HumanaAccess spending account information
- View plans and coverage details, including deductibles
- Pay bill balances
- Find a telehealth provider
- Get information and resources on the COVID-19 pandemic

23. What is your 2021 target Per Member Per Month (PMPM) medical cost for your network?

This is not applicable to Group Medicare Advantage plans.

24. For what procedures do you offer Centers for Excellence program? Please provide a listing of locations utilized by procedure.

Humana has established Centers of Excellence (COEs) for the management of all transplants ventricular assist devices (VAD) patients. Additionally, while we do not utilize COEs for cancer, the Oncology Quality Management program is included in our MAPD plans.

Transplant Management
Humana offers our National Transplant Network as the COE program to members who need high-cost, highly specialized transplant procedures. Each transplant facility in our network is chosen based on a review of the program's outcomes, annual volume, survival rates, and accreditation. We negotiate network contracts with leading transplant centers located throughout the Unites States to best serve our members. Humana also continues to evaluate more centers for participation in our National Transplant Network.

Please refer to the National Transplant Network website located at **humana.com/individual-and-family-support/benefits/health-resources/transplant-services** for a list of facilities in our National Transplant Network. Network providers are subject to change and vary by transplant type. The list includes the

facility name, location, transplant service type, and program type (adult, pediatric). To confirm a facility's participation in the National Transplant Network, the member may call 1-866-421-5663.

Our National Transplant Network facilities are approved by CMS.

In addition to the National Transplant Network of COE facilities, Humana maintains a dedicated team whose sole focus is caring for members throughout the transplant process and managing and maximizing a member's benefits for organ and stem cell transplants. Humana's Transplant Management program has delivered dedicated transplant care managers (registered nurses) to help enhance members' quality of life, while helping them understand the transplant process, and get the most from their benefits in the most cost-effective way. Once members are identified and referred to the program, their dedicated care manager works with them and their providers during the planning stages, the procedure, the hospital stay, and for one-year post-transplant.

VAD
We added a COE designation to our transplant facilities with experience in VAD for both transplant patients and destination therapy. VAD use continues to grow, and COE designation enables us to direct members to hospitals with experience implanting these expensive devices successfully and in a cost-effective manner.

The COE for VAD will allow Humana to direct members to hospitals with experience in implanting these devices and managing patients for the best possible outcomes. The COE will include clinical care management pre- and post-hospital stay to ensure members understand what their benefits provide and how to have a successful implant experience. Contracts will include reimbursement terms specific to VAD procedures, and dedicated claims specialists will adjudicate these claims. Humana follows VAD members indefinitely, until they are transplanted, leave the plan, or are no longer in need of services.

25. A provider network is a critical part of the medical plan; therefore, include provider directory with your proposal. Also, provide a GEO Access report using a standard of two (2) providers within ten (10) miles.

Following are the instructions for reaching our provider search tool:
- Click on or type in this link: **humana.com/finder/provider-directories**
- Select the state needed
- Scroll down for a list of each directory for each market and network

Please refer to Section XI for a Network Accessibility Report.

26. Is MD Anderson Cancer Center, located in Houston, TX, a network provider?

MD Anderson Cancer Center is not a contracted provider; however, specific to Group Medicare, if a member is accepted by MC Anderson Cancer Center, they have agreed to bill Humana for services.

27. What disease management programs do you currently have in place?

Rather than designing a separate program for each chronic condition, Humana's Care Management program focuses on the whole person, allowing the member to receive the correct level of support

based on what is needed for his or her situation. We have found this approach to be more effective than traditional disease management programs since many members are dealing with more than one condition.

We do this through the Humana telephonic Care Management program, available to Medicare Advantage members with chronic support needs. Humana maximizes program engagement in our telephonic Care Management program by engaging them at the right time, in the right place, through data-driven predictive analytics and proactive outreach by our Care Management team.

Support for members with chronic conditions has migrated towards disease-specific best practices. These practices focus on promoting healthy behaviors, resulting in quality outcomes that improve the health of members living with high-priority conditions such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, musculoskeletal issues, weight complications, Fibromyalgia, Hepatitis C, and irritable bowel syndrome. The goal is to use disease-specific metrics to create optimally managed members who follow necessary guidelines per these conditions.

For example, within our holistic support model, we include member-specific support with a focus on finding and closing priority gaps in care. These include medication adherence and medication treatment gaps, as well as gaps relating to screening/monitoring, and out-of-range lab values (e.g., HbA1c control for members with diabetes). These targeted gaps have demonstrated value in driving improved outcomes for our members.

Please refer to Attachment G, Humana Clinical Touchpoints for more information.

28. Describe your current Wellness Program options and results, including what programs are provided to assist in healthy living. Do you provide an onsite wellness program?

Humana's Go365 program is an innovative and effective wellness solution that incents members to reach their optimal health. This turnkey solution applies to approximately 5 million members. By participating in measurable health-related activities and adopting behaviors that result in lower health risks—such as taking wellness classes, exercising, and getting regular medical check-ups and screenings—Jefferson Parish's members earn rewards that can be redeemed for gift cards in the Go365 Mall. In 2022, members can receive rewards in the form of gift cards to be redeemed by the end of the calendar year.

Introduction to the Program
All new Medicare Go365 members receive information within six weeks of the plan's effective date, as part of Humana's Well-being Guide. It will give them the information they need to begin participating either online or offline.

Go365 is designed to deliver the core elements of a wellness program in a seamless, easy-to-understand, and motivational manner. The program allows seniors to participate in healthy activities, such as preventive screenings, exercise and fitness and social and educational activities and includes health coaching.

Engage in healthy activities

Members can engage in the program however they like. They may choose to complete any of the eligible activities in the program to earn rewards:

- **Social and educational activities:** Socializing and getting involved in community activities are key factors for seniors to try to stay healthy. That is why we reward members for things like completing an athletic event like a 5k walk, volunteering, taking a health education class or connecting virtually with friends or family.
- **Exercise and Fitness:** Members can see how a physically active lifestyle can greatly benefit their health. Go365 members can earn rewards for attending SilverSneakers Fitness centers or by utilizing an activity tracker, like a pedometer, to track their daily workouts.
- **Preventive Screenings:** Medicare Advantage members earn rewards for the following preventive services:
  - Annual wellness exam
  - Bone density screening
  - Cardiovascular disease screening
  - Colorectal screening
  - Flu shot
  - Mammogram
  - Diabetes specific screenings including an eye exam, kidney function test, HbA1c and foot exam

Enjoy the Go365 Mall

In addition to the physical and social benefits of maintaining or improving the health and wellness of our members, the Go365 Mall is another exciting part of engaging in the program. Members have until December 31st of each year to redeem their rewards.

The Go365 Mall offers popular gift cards, including Walmart, CVS, Walgreens, Kohl's, Lowe's, Kroger, Subway, and Shell.

A Fitting Experience

We provide both online and offline Go365 experiences for Medicare members depending on their preference:

- **Online:** Members engage in Go365 through our website where they can view their activity dashboard to see what activities they have completed, the rewards they have earned and what their Next Best Step is.
- **Offline:** Members engage in Go365 via paper, where materials are sent through the mail. Members redeem their rewards over the phone through our automated system.

Neighborhood Centers

Locally, we offer Humana neighborhood locations in areas where Humana has significant populations of Medicare Advantage members. These highly visible storefronts are designed to respond to the needs of the local community. Placed to provide easy access to their target markets of members 55 and over, the centers welcome anyone of any age to participate in most programs, free of charge, whether a Humana member or not. Each center is staffed with a coordinator to greet and assist guests, a Humana customer care specialist (either on site for in-person assistance or virtually via "Skype-like" technology) and a sales agent of the day to answer member questions or assist non-members seeking information.

Each location offers a place for members to connect with others, participate in a chronic condition class taught by a clinician, volunteer, learn a new craft or board game, take a class to help members improve their balance, and learn about ways to get and stay healthy. Members can also join in one of our SilverSneakers fitness classes or get connected with a Humana pharmacist or clinician.

Louisiana locations include: Metairie, Lake Charles, Shreveport, Lafayette, Baton Rouge.

SilverSneakers
SilverSneakers, the nation's leading fitness program designed specifically to keep seniors healthy, has been offered to Humana Medicare Advantage and Medicare Supplement members since 2004. Currently, around 4.6 million of our members are eligible to participate in SilverSneakers. We are demonstrating our long-term, ongoing dedication to older-adult plan members through this time-tested, proven solution that provides a unique combination of exercise and social support.

Humana Medicare members can use any of thousands of participating locations in the SilverSneakers network, and are not limited to just one location. Members have access to the amenities as part of a basic membership, which can include steam and sauna rooms, heated pools, body conditioning classes, and strengthening tools, in addition to exercise equipment and weights. Members may also participate in SilverSneakers classes offered at select locations. Classes are designed to increase strength, balance, and flexibility and are led by instructors trained specifically in senior fitness. In addition, members may access online workshops and exercise videos through SilverSneakers On-Demand™, and use the SilverSneakers GO™ app to schedule workouts and find participating locations.

A new enhancement that began in 2020 is the ability for members to engage in live virtual classes online or through the GO app. These live virtual classes are offered every day of the week so that members can participate from the comfort and safety of their home, offering members an opportunity stay active and connected while visiting a location may be more difficult.

Using proven methodologies based upon more than 25 years of science and outcomes, the SilverSneakers fitness program increases physical activity in seniors, often resulting in improved well-being and lower health care costs. The program engages participants in active behavior change through access to a variety of physical activity venues and senior-specific programming that incorporates physical fitness and social experiences.

The enduring success of the program is evidenced through our members' responses to the SilverSneakers fitness program annual member survey. The national survey found that Humana's SilverSneakers members self-report better physical, emotional, and overall health, as well as a lower disease burden and a reduced incidence of chronic conditions, than the national averages for seniors in the U.S. Our SilverSneakers participants also reported reductions in pain experienced due to arthritis, lower back problems, and sciatica. The majority of new SilverSneakers enrollees who previously had no activity indicated that they exercised more than twice as often over the past year.

There are currently more than 16,000 contracted SilverSneakers participating locations nationwide. Participating locations may be found by city, ZIP code, or full address at **SilverSneakers.com/Locations**.

29. Describe your pharmacy network.

Humana's robust network currently has over 63,000 retail pharmacies in all 50 states, Puerto Rico, Guam, and the United States Virgin Islands, including every major national and regional chain as well as over 22,000 popular independent local pharmacies, giving most members convenient or reasonable access to multiple pharmacy locations. Major chains in our pharmacy network include:

- Albertson's/SuperValu
- Costco
- CVS Pharmacy
- Kash n' Karry
- Kroger
- Meijer
- Osco
- Publix
- Safeway
- Target
- Walgreens
- Walmart
- Winn-Dixie

More than 99% of these pharmacies dispense 90-day prescriptions, and all pharmacies within our retail network are contracted to dispense specialty prescriptions when available. Humana also provides members solutions for extended day supply medications, long-term care pharmacy services, home infusion pharmacy services, compounding pharmacy services, and mail-order pharmacy.

30. How many Prescription Drug Lists (PDL's) does your company administer?

Humana administers 46 unique Group Medicare prescription drug lists for our groups. Additionally, we create abbreviated, comprehensive English and Spanish lists totaling 184 PDLs.

Humana is proposing one formulary for Jefferson Parish; this current formulary offers richer benefits that Humana's individual plan offering.

31. If more than one PDL, what is the pricing differentials for each PDL and what is the impact on premiums and co-pays?

Humana is proposing one formulary for Jefferson Parish.

Our tiers for our proposed Group Plus 4-tiered formulary include:

- Tier 1: Generic (some high-cost Generics can fall in higher Tiers)
- Tier 2: Preferred Brand
- Tier 3: Non-Preferred Drug
- Tier 4: Specialty*

*Specialty drugs are defined by CMS as any therapy costing in excess of $830 (for 2022) per month.

32. Based on the top 100 drugs based on prescriptions filled, please identify which tier each drug falls under in your company's PDL.

Please refer to Section XII for the top 100 NDCs by Tier.

33. Describe your mail order capabilities.

CenterWell Pharmacy, Inc. and CenterWell Specialty Pharmacy manage our mail order services. CenterWell Pharmacy performs front end processing in Arizona and Ohio with dispensing from our West Chester facility. We also have a smaller, secondary specialty facility in Miramar, Florida:

- Each pharmacy stores different types of medicine and uses their own ordering systems
- Members who use both pharmacies will receive separate invoices and shipments arrive separately
- Both mail prescriptions directly to members, and standard shipping is free
- Regular prescriptions are typically shipped via United States Postal Service first class mail. Cold-packed, controlled substances, and specialty prescriptions are shipped via UPS for tracking purposes.

Humana takes pride in providing excellent customer service. When members call our customer care center, our specialists will facilitate a "warm transfer" to CenterWell Pharmacy and, with the member's permission, will stay on the line to be sure the assistance requested is completed. Members can also contact CenterWell Pharmacy to speak directly with a Pharmacy team member. If members have questions about their medications, Pharmacy representatives can connect members with a pharmacist or technician for further assistance. Pharmacists are on call for consultation 24 hours a day, seven days a week.

CenterWell Pharmacy is accredited by URAC, the premier quality organization working in healthcare, for mail service pharmacy. Additionally, CenterWell Pharmacy achieved the No. 1 ranking for Mail Order Pharmacy customer satisfaction by J.D. Power in their 2021 U.S. Pharmacy Study. It marks the fourth year in a row that CenterWell Pharmacy has captured the honor. The study ranks four categories:

- Prescription ordering and filling process
- Cost competitiveness
- Prescription delivery
- Customer service experience

CenterWell Specialty Pharmacy offers medicines to treat chronic and complex conditions such as rheumatoid arthritis, multiple sclerosis, cancer, hemophilia and other conditions. CenterWell Specialty Pharmacy is a three-time winner (2018, 2019 and 2020) of the J.D. Power Zitter Specialty Pharmacy Patient Choice Award in the PBM/Payer category.

34. What is your market share in your local market based on membership for 2019, 2020 and 2021?

Humana is the leader in the Medicare Advantage space in Louisiana, having 51% of Medicare Advantage members in the state as of August 2022, with almost double the membership of our nearest competitor. Locally, Humana maintains over 58% of the Medicare Advantage market nearest Jefferson Parish.

35. What was your Louisiana profit/loss in 2020 and 2021? Please provide your 2020 or 2021 financial report.

Humana considers profit/loss statement by state proprietary information.

Please refer to Attachment H for audited financial reports for 2020 and 2021.

You may also refer to our most recent quarterly (10-Q) and annual (10-K) financial and business reports filed with the Securities and Exchange Commission (SEC) for any pending or recently completed, publicly announced transactions. These documents can be found online at **Humana.com** under Investor Relations - SEC Filings.

ATTACHMENT E

SOQ AFFIDAVIT

Statement of Qualifications
Affidavit Instructions

- **Affidavit is supplied as a courtesy to Affiants, but it is the responsibility of the affiant to insure the affidavit they submit to Jefferson Parish complies, in both form and content, with federal, state and parish laws.**
- **Affidavit must be signed by an authorized representative of the entity or the affidavit will not be accepted.**
- **Affidavit must be notarized or the affidavit will not be accepted.**
- **Notary must sign name, print name, and include bar/notary number, or the affidavit will not be accepted.**
- **Affiant MUST select either A or B when required or the affidavit will not be accepted.**
- **Affiants who select choice A must include an attachment or the affidavit will not be accepted.**
- **If both choice A and B are selected, the affidavit will not be accepted.**
- **Affidavit marked N/A will not be accepted.**
- **It is the responsibility of the Affiant to submit a new affidavit if any additional campaign contributions are made after the affidavit is executed but prior to the time the council acts on the matter.**

Instruction sheet may be omitted when submitting the affidavit

Statement of Qualifications

AFFIDAVIT

STATE OF Kentucky

PARISH/COUNTY OF Jefferson

BEFORE ME, the undersigned authority, personally came and appeared: Steven McCulley

_____, (Affiant) who after being by me duly sworn, deposed and said that he/she is the fully authorized Senior Vice President, Medicare Administration of Humana (Entity), the party who submitted a Statement of Qualifications (SOQ) to Group Medicare Advantage Plan with a National Provider Network for all Eligible Retirees and Dependents (Briefly describe the services the SOQ will cover), to the Parish of Jefferson.

Affiant further said:

Campaign Contribution Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Attached hereto is a list of all campaign contributions, including the date and amount of each contribution, made to current or former elected officials of the Parish of Jefferson by Entity, Affiant, and/or officers, directors and owners, including employees, owning 25% or more of the Entity during the two-year period immediately preceding the date of this affidavit or the current term of the elected official, whichever is greater. Further, Entity, Affiant, and/or Entity Owners have not made any contributions to or in support of current or former members of the Jefferson Parish Council or the Jefferson Parish President through or in the name of another person or legal entity, either directly or indirectly.

Choice B X there are **NO** campaign contributions made which would require disclosure under Choice A of this section.

Affiant further said:

Debt Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Attached hereto is a list of all debts owed by the affiant to any elected or appointed official of the Parish of Jefferson, and any and all debts owed by any elected or appointed official of the Parish to the Affiant.

Choice B _X___ There are **NO** debts which would require disclosure under Choice A of this section.

Affiant further said:

Solicitation of Campaign Contribution Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Attached hereto is a list of all elected officials of the Parish of Jefferson, whether still holding office at the time of the affidavit or not, where the elected official, individually, either by **telephone or by personal contact,** solicited a campaign contribution or other monetary consideration from the Entity, including the Entity's officers, directors and owners, and employees owning twenty-five percent (25%) or more of the Entity, during the two-year period immediately preceding the date the affidavit is signed. Further, to the extent known to the Affiant, the date of any such solicitation is included on the attached list.

Choice B _X___ there are **NO** solicitations for campaign contributions which would require disclosure under Choice A of this section.

Affiant further said:

Subcontractor Disclosures

(Choose A or B, if option A is indicated please include the required attachment):

Choice A _____ Affiant further said that attached is a listing of all subcontractors, excluding full time employees, who may assist in providing professional services for the aforementioned SOQ.

Choice B _X___ There are **NO** subcontractors which would require disclosure under Choice A of this section.

Affiant further said:

That Affiant has employed no person, corporation, firm, association, or other organization, either directly or indirectly, to secure the public contract under which he received payment, other than persons regularly employed by the Affiant whose services in connection with the construction, alteration or demolition of the public building or project or in securing the public contract were in the regular course of their duties for Affiant; and

[*The remainder of this page is intentionally left blank.*]

That no part of the contract price received by Affiant was paid or will be paid to any person, corporation, firm, association, or other organization for soliciting the contract, other than the payment of their normal compensation to persons regularly employed by the Affiant whose services in connection with the construction, alteration or demolition of the public building or project were in the regular course of their duties for Affiant.

Signature of Affiant

Steven McCulley, Senior Vice President, Medicare Administration
Printed Name of Affiant

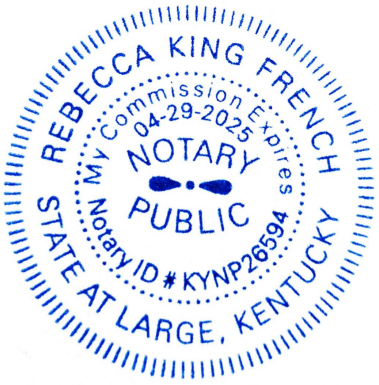
SWORN AND SUBSCRIBED TO BEFORE ME

ON THE 16th DAY OF August, 2022.

Notary Public

Rebecca King French
Printed Name of Notary

KYNP26594
Notary/Bar Roll Number



My commission expires April 29, 2025.

PLAN DESIGN EXHIBITS

HUMANA MEDICARE EMPLOYER LPPO PLAN

2023 LPPO for Jefferson Parish Government Plan 079 Option TBD1 - Passive

Effective Date: 01/01/2023 - 12/31/2023

Annual Maximum Out-of-Pocket	• In-Network: $2,500 per individual per plan year (excludes Part D Pharmacy, Dental Services (Routine), Hearing Services (Routine), OTC Drugs and Supplies, Vision Services (Routine), Extra Services and the Plan Premium)		
	• Combined In and Out-of-Network: $2,500 per individual per plan year (excludes Part D Pharmacy, Dental Services (Routine), Hearing Services (Routine), OTC Drugs and Supplies, Vision Services (Routine), Worldwide Coverage and the Plan Premium)		
Annual Deductible	• Combined In and Out-of-Network: None		
	• In-Network Exclusions: N/A		
	• Out-of-Network Exclusion: N/A		
Place of Treatment	**Benefit**	**Network Coverage Plan Pays (1):**	**Non-Network Coverage Plan Pays (1):**
Primary Care Physician	• Office Visit	100% after $5 copayment	100% after $5 copayment
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	100%	100%
	• Surgical Procedures	100% after $5 copayment	100% after $5 copayment
	• Allergy Shots and Injections	100%	100%
	• Mental Health/Substance Abuse Services	100% after $5 copayment	100% after $5 copayment
	• Administration of Drugs in a Physician's Office	80%	80%
Specialist	• Office Visit	100% after $20 copayment	100% after $20 copayment
	• Advanced Imaging Services	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	100%	100%
	• Surgical Procedures	100% after $20 copayment	100% after $20 copayment
	• Diagnostic Colonoscopy	100% after $20 copayment	100% after $20 copayment
	• Podiatry Services (Medicare-covered)	100% after $20 copayment	100% after $20 copayment
	• Chiropractic Services (Medicare-covered)	100% after $20 copayment	100% after $20 copayment
	• Cardiac Therapy	100% after $20 copayment	100% after $20 copayment
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100% after $20 copayment	100% after $20 copayment
	• Pulmonary Therapy	100% after $20 copayment	100% after $20 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $20 copayment	100% after $20 copayment
	• Radiation Therapy	100% after $20 copayment	100% after $20 copayment
	• Allergy Shots and Injections	100%	100%
	• Mental Health/Substance Abuse Services	100% after $20 copayment	100% after $20 copayment
	• Opioid Treatment Services	100% after $20 copayment	100% after $20 copayment
	• Administration of Drugs in a Physician's Office	80%	80%
	• Chemotherapy Drugs	100% after $20 copayment	100% after $20 copayment
	• Dental Services (Medicare-covered)	100% after $20 copayment	100% after $20 copayment

	• Hearing Services (Medicare-covered)	100% after $20 copayment	100% after $20 copayment
	• Vision Services (Medicare-covered)	100% after $20 copayment	100% after $20 copayment
	• Eyewear for Post-Cataract Surgery	100% • For eyeglasses and contacts following cataract surgery	100% • For eyeglasses and contacts following cataract surgery
	• Diabetic Eye Exam	100%	100%
	• Acupuncture (Medicare-covered) - Limited to 20 combined visit(s) per year - Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	100% after $20 copayment	100% after $20 copayment
Preventive Services	• Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Lung Cancer Screening • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • STI Screening and Counseling • Smoking and Tobacco Use Cessation • "Welcome to Medicare" Preventive Visit	100%	100%
	• Immunizations	100%	100%
	• Medicare Diabetes Prevention Program (MDPP)	100%	100%
Inpatient Hospital Services	• Inpatient Care (all authorized admissions)	100% after $150 copayment per day (days 1-5)	100% after $150 copayment per day (days 1-5)
	• Inpatient Physician Services	100%	100%
	• Inpatient Mental Health Care/Substance Abuse Services (all authorized admissions)	100% after $150 copayment per day (days 1-5)	100% after $150 copayment per day (days 1-5)
Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (all authorized admissions)	100% after $150 copayment per day (days 1-5) • 190 day lifetime limit in a psychiatric facility	100% after $150 copayment per day (days 1-5) • 190 day lifetime limit in a psychiatric facility
	• Inpatient Mental Health/Substance Abuse Physician Services	100%	100%
Partial Hospitalization	• Mental Health/Substance Abuse Services	100% after $20 copayment	100% after $20 copayment
	• Opioid Treatment Services	100% after $20 copayment	100% after $20 copayment

Outpatient Hospital Services	• Surgical Services	100% after $100 copayment	100% after $100 copayment
	• Diagnostic Colonoscopy	100% after $100 copayment	100% after $100 copayment
	• Advanced Imaging Services	100% after $50 copayment	100% after $50 copayment
	• Nuclear Medicine Services	100% after $50 copayment	100% after $50 copayment
	• Diagnostic Procedures and Tests	100%	100%
	• Lab Services	100%	100%
	• Radiation Therapy	100%	100%
	• Cardiac Therapy	100% after $40 copayment	100% after $40 copayment
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100% after $30 copayment	100% after $30 copayment
	• Pulmonary Therapy	100% after $30 copayment	100% after $30 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $40 copayment	100% after $40 copayment
	• Chemotherapy Drugs	100% after $50 copayment	100% after $50 copayment
	• Renal Dialysis Services	80%	80%
	• Mental Health/Substance Abuse Services	100% after $40 copayment	100% after $40 copayment
	• Opioid Treatment Services	100% after $40 copayment	100% after $40 copayment
	• Outpatient Physician Services	100%	100%
Skilled Nursing Facility (SNF)	• SNF Care (no 3-day hospital stay is required)	100% per day (days 1-20); 100% after $25 copayment per day (days 21-100) • Plan pays $0 after 100 days	100% per day (days 1-20); 100% after $25 copayment per day (days 21-100) • Plan pays $0 after 100 days
	• SNF Physician Services	100%	100%
Urgent Care Center	• Urgently Needed Care	100% after $20 copayment	100% after $20 copayment
	• Lab Services	100%	100%
Emergency Room	• Emergency Services **(2)**	100% after $65 copayment; waived if admitted within 24 hours	100% after $65 copayment; waived if admitted within 24 hours
	• Emergency Room Physician Services	100%	100%
Ambulance	• Ambulance Services	100% after $50 copayment per date of service • Limited to Medicare-covered transportation	100% after $50 copayment per date of service • Limited to Medicare-covered transportation
Network Provider	• US Travel Benefit	• Member receives in-network benefits when services are received from a participating PPO provider in another Humana PPO service area.	N/A
Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	N/A	100% after $65 copayment • Waived if admitted within 24 hours • Limited to emergency Medicare-covered services.
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100% after $20 copayment	100% after $20 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $20 copayment	100% after $20 copayment
Freestanding Radiological Facility	• Advanced Imaging Services	100%	100%
	• Nuclear Medicine Services	100%	100%
	• Diagnostic Procedures and Tests	100%	100%
	• Radiation Therapy	100%	100%

Ambulatory Surgical Center	• Surgical Procedures	100% after $75 copayment	100% after $75 copayment
	• Diagnostic Colonoscopy	100% after $75 copayment	100% after $75 copayment
Freestanding Laboratory	• Lab Services	100%	100%
Dialysis Center	• Renal Dialysis Services	100%	100%
Home Health	• Home Health Care	100% • Excludes Personal Home Care	100% • Excludes Personal Home Care
DME Provider	• Durable Medical Equipment	90%	90%
	• Diabetic Monitoring Supplies	100%	100%
Medical Supply Provider	• Medical Supplies	90%	90%
Prosthetics Provider	• Prosthetics	90%	90%
Pharmacy (PART B ONLY)	• Durable Medical Equipment	90%	90%
	• Medical Supplies	90%	90%
	• Diabetic Monitoring Supplies	100%	100%
	• Medicare-covered Part B Drugs	80%	80%
Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%	Not Available
	• Specialist - Virtual Visit	100% after $20 copayment	Not Available
	• Behavioral Health and Substance Abuse - Virtual Visit	100%	Not Available
	• Urgently Needed Care - Virtual Visit	100%	Not Available

Other Benefits	• Dental Services (Routine) - DENTBD	•100% for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. •100% for bitewing x-rays up to 1 set(s) per year. •100% for periodic oral exam, prophylaxis (cleaning) up to 2 per year. •100% for necessary anesthesia with covered service up to unlimited per year. •50% for amalgam and/or composite filling up to 2 per year. •$1,000 maximum benefit coverage amount per year for preventive and comprehensive benefits.	•100% for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. •100% for bitewing x-rays up to 1 set(s) per year. •100% for periodic oral exam, prophylaxis (cleaning) up to 2 per year. •100% for necessary anesthesia with covered service up to unlimited per year. •50% for amalgam and/or composite filling up to 2 per year. •$1,000 maximum benefit coverage amount per year for preventive and comprehensive benefits. •Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
	• Hearing Services (Routine) - HER215	•100% for routine hearing exams up to 1 per year. •100% for follow-up provider visits up to unlimited per year. •100% after $699 copayment for each Advanced level hearing aid up to 1 per ear per year. •100% after $999 copayment for each Premium level hearing aid up to 1 per ear per year. •Note: Includes 80 batteries per aid and 3 year warranty. •Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.	•100% for routine hearing exams up to 1 per year. •100% for follow-up provider visits up to unlimited per year. •100% after $699 copayment for each Advanced level hearing aid up to 1 per ear per year. •100% after $999 copayment for each Premium level hearing aid up to 1 per ear per year. •Note: Includes 80 batteries per aid and 3 year warranty. •Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. •Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
	• OTC Drugs and Supplies - OTC305	•$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.	•Not Available
	• Vision Services (Routine) - VISTBD	•100% after $15 copayment for routine exam (includes refraction) up to 1 per year. •$200 maximum benefit coverage amount for eyeglasses-frames up to 1 per year. •$120 maximum benefit coverage amount for premium progressive lenses up to 1 per year. •100% for eyeglasses-lenses or contact lenses up to 1 per year.	•100% after $15 copayment for routine exam (includes refraction) up to 1 per year. •$200 maximum benefit coverage amount for eyeglasses-frames up to 1 per year. •$120 maximum benefit coverage amount for premium progressive lenses up to 1 per year. •100% for eyeglasses-lenses or contact lenses up to 1 per year. •Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.		
Extra Benefits (MSB)	• SilverSneakers®	In most service areas members will have free membership to a local fitness center through the SilverSneakers program.
	• Personal Health Coaching	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.
	• Smoking Cessation (Additional)	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.
	• Meal Program	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.
	• Post-Discharge Transportation Services	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by car, van or wheelchair accessible vehicle at no cost.
	• Post-Discharge Personal Home Care	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.
Care Management	• Clinical Programs/Disease Management **(3)** *- Case Management* *- Humana At Home®* *- Chronic Condition Management* *- Transplant Management* *- Behavioral Health Care Coordination*	Health education and clinical programs that provide support to members and caregivers to optimize health outcomes.

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a "per visit" basis, unless otherwise noted.

(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.

(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.

2023 COVID-19 Testing and Treatment Update: Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of the member's Humana membership card. CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Extra Services (VAIS)	• Complementary and Alternative Medicine and Weight Management - Not available in Puerto Rico	Discounts for complementary and alternative medicine services including chiropractic, acupuncture, massage therapy and nutrition. Services must be received from participating designated providers.
	• Dental Discount (HumanaDental) - Not available in Florida or Puerto Rico	Discounts on dental services. Services must be received from participating HumanaDental providers.
	• Dental Discount (Careington Dental) - Available in Florida only	Discounts on dental services. Services must be received from participating Careington providers.
	• Healthy Hearing Discount (HearUSA) - Available in Florida only	Discounts on hearing aids, accessories and hearing assistance products.
	• Hearing Discount (TruHearing) - Not available in Florida or Puerto Rico	Discounts on hearing aids. Services must be received at a TruHearing hearing center.
	• Lifeline® Medical Alert Systems	Philips Lifeline may help members live independently with peace of mind. Personal emergency response services connect members to caregivers and emergency services when an incident occurs. Wireless or landline options available.
	• Meal Delivery Discount	Discounts on home delivered meals to help support nutritional needs. Purchases may be placed online at MomsMeals.com/welldine or by calling 1.877.347.3438.
	• Vision Discount (EyeMed)	Discounts from participating EyeMed Vision Care Select network providers on routine vision services such as: Exam, contact lens fitting and follow-up, lenses, frames and laser vision correction. Discounts are taken at point of sale. Discount and funded benefits cannot be utilized within the same transaction.

Go365® by Humana is included in this plan

Go365 is a wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help them establish and maintain a healthy lifestyle. As they achieve manageable health goals, Go365 keeps members engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting an Annual Wellness Exam, or volunteering, members earn rewards they can redeem for gift cards in the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Certain services under the plan require authorization by network providers. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

HUMANA MEDICARE EMPLOYER Rx PLAN

2023 Rx for Standard Plan Rx 1
Group Plus Formulary - PDG 2

30 day Supplies

Plan/ Option	30 day Standard Retail from $0 to Catastrophic (1)				30 day Standard Retail from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$10	$20	$40	25%	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance.	$7,400

Plan/ Option	30 day Standard Mail Order from $0 to Catastrophic (1)				30 day Standard Mail Order from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$10	$20	$40	25%	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance.	$7,400

*Tier 1: Generic or Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.
Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand drugs.
Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

90 day Supplies

Plan/ Option	90 day Standard Retail (2) from $0 to Catastrophic (1)				90 day Standard Retail (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$30	$60	$120	N/A	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance.	$7,400

Plan/ Option	90 day Standard Mail Order (2) from $0 to Catastrophic (1)				90 day Standard Mail Order (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$0	$40	$80	N/A	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance.	$7,400

Footnotes

1 Catastrophic: When a member's True Out Of Pocket (TrOOP) cost reaches $7,400.

2 Retail and Mail Order: Retail and Mail Order benefit for a 90-day supply is limited to Rx formulary Tiers 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30-day supply.

Out of Network: Emergency Situations

When a member purchases a drug at an out-of-network pharmacy in an emergency situation:

a. the member will pay the same coinsurance as would have applied at a network pharmacy, but at the out-of-network pharmacy price, and/or,

b. the member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out-of-network pharmacy price and the network pharmacy price.

Extra Services

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Prescription Medication Discount	Members show their Humana member ID card at participating pharmacies when they buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer Prescription Drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

HUMANA MEDICARE EMPLOYER HMO PLAN

2023 HMO for Jefferson Parish Government Plan 076 Option 256 - Louisiana Only

Effective Date: 01/01/2023 - 12/31/2023

Annual Maximum Out-of-Pocket	• **In-Network: $2,500 per individual per plan year (excludes Part D Pharmacy, Extra Services, and the Plan Premium).**	
Annual Deductible	• **In-Network: NONE**	
	• **In-Network Exclusions: N/A**	
Place of Treatment	**Benefit**	**Network Coverage Plan Pays (1):**
Primary Care Physician	• Office Visit	100% after $5 copayment
	• Diagnostic Procedures and Tests	100%
	• Lab Services	100%
	• Surgical Procedures	100% after $5 copayment
	• Allergy Shots and Injections	100%
	• Mental Health/Substance Abuse Services	100% after $5 copayment
	• Administration of Drugs in a Physician's Office	80%
Specialist	• Office Visit	100% after $20 copayment
	• Advanced Imaging Services	100%
	• Diagnostic Procedures and Tests	100%
	• Lab Services	100%
	• Surgical Procedures	100% after $20 copayment
	• Diagnostic Colonoscopy	100% after $20 copayment
	• Podiatry Services (Medicare-covered)	100% after $20 copayment
	• Chiropractic Services (Medicare-covered)	100% after $20 copayment
	• Cardiac Therapy	100% after $20 copayment
	• Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	100% after $20 copayment
	• Pulmonary Therapy	100% after $20 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $20 copayment
	• Radiation Therapy	100% after $20 copayment
	• Allergy Shots and Injections	100%
	• Mental Health/Substance Abuse Services	100% after $20 copayment
	• Opioid Treatment Services	100% after $20 copayment
	• Administration of Drugs in a Physician's Office	80%
	• Chemotherapy Drugs	100% after $20 copayment
	• Dental Services (Medicare-covered)	100% after $20 copayment
	• Hearing Services (Medicare-covered)	100% after $20 copayment
	• Vision Services (Medicare-covered)	100% after $20 copayment
	• Eyewear for Post-Cataract Surgery	100% •for eyeglasses and contacts following cataract surgery
	• Diabetic Eye Exam	100%
	• Acupuncture (Medicare-covered) • Limited to 20 visit(s) per year • Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	100% after $20 copayment
Preventive Services	• Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Immunizations • Lung Cancer Screening • Medicare Diabetes Prevention Program • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • Smoking and Tobacco Use Cessation • STI Screening and Counseling • "Welcome to Medicare" Preventive Visit	100%
Inpatient Hospital Services	• Inpatient Care (All Authorized Admissions)	100% after $150 copayment per day (days 1-5)
	• Inpatient Physician Services	100%
	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% after $150 copayment per day (days 1-5)

Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% after $150 copayment per day (days 1-5) •190 day lifetime limit in a psychiatric facility
	• Inpatient Mental Health/Substance Abuse Physician Services	100%
Partial Hospitalization	• Mental Health/Substance Abuse Services	100% after $20 copayment
	• Opioid Treatment Services	100% after $20 copayment
Outpatient Hospital	• Surgical Services	100% after $100 copayment
	• Diagnostic Colonoscopy	100% after $100 copayment
	• Advanced Imaging Services	100% after $50 copayment
	• Nuclear Medicine Services	100% after $50 copayment
	• Diagnostic Procedures and Tests	100%
	• Lab Services	100%
	• Radiation Therapy	100%
	• Cardiac Therapy	100% after $40 copayment
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100% after $30 copayment
	• Pulmonary Therapy	100% after $30 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $40 copayment
	• Chemotherapy Drugs	100% after $50 copayment
	• Renal Dialysis Services	80%
	• Mental Health/Substance Abuse Services	100% after $40 copayment
	• Opioid Treatment Services	100% after $40 copayment
	• Outpatient Physician Services	100%
Skilled Nursing Facility (SNF)	• SNF Care (no 3 day hospital stay is required)	100% per day (days 1-20); $25 copayment per day (days 21-100) •Plan pays $0 after 100 days
	• SNF Physician Services	100%
Urgent Care Center	• Urgently Needed Care	100% after $20 copayment
	• Lab Services	100%
Emergency Room	• Emergency Services **(2)**	100% after $65 copayment • Waived if admitted within 24 hours
	• Emergency Room Physician Services	100%
Ambulance	• Ambulance Services	100% after $50 copayment per date of service •Limited to Medicare-covered transportation
Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	100% after $65 copayment • Waived if admitted within 24 hours Limited to emergency Medicare-covered services.
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100% after $20 copayment
	• Therapies (Occupational, Physical, Audiology, and Speech)	100% after $20 copayment
Freestanding Radiological Facility	• Advanced Imaging Services	100%
	• Nuclear Medicine Services	100%
	• Diagnostic Procedures and Tests	100%
	• Radiation Therapy	100%
Ambulatory Surgical Center	• Surgical Procedures	100% after $75 copayment
	• Diagnostic Colonoscopy	100% after $75 copayment
Freestanding Laboratory	• Lab Services	100%
Dialysis Center	• Renal Dialysis Services	100%
Home Health	• Home Health Care	100% •excludes Personal Home Care
DME Provider	• Durable Medical Equipment	90%
	• Diabetic Monitoring Supplies	100%
Medical Supply Provider	• Medical Supplies	90%
Prosthetics Provider	• Prosthetics	90%
Pharmacy (Part B Only)	• Durable Medical Equipment	90%
	• Medical Supplies	90%
	• Diabetic Monitoring Supplies	100%
	• Medicare-covered Part B Drugs	80%
Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%
	• Specialist - Virtual Visit	100% after $20 copayment
	• Behavioral Health and Substance Abuse - Virtual Visit	100%
	• Urgently Needed Care - Virtual Visit	100%

Other Benefits	• Dental Services (Routine)	•100% for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. •100% for bitewing x-rays up to 1 set(s) per year. •100% for periodic oral exam, prophylaxis (cleaning) up to 2 per year. •100% for necessary anesthesia with covered service up to unlimited per year. •50% for amalgam and/or composite filling up to 2 per year. •$1,000 maximum benefit coverage amount per year for preventive and comprehensive benefits. - DEN215
	• Hearing Services (Routine)	•100% coinsurance for routine hearing exams up to 1 per year. •100% coinsurance for follow-up provider visits up to unlimited per year. •100% after $699 copayment for each Advanced level hearing aid up to 1 per ear per year. •100% after $999 copayment for each Premium level hearing aid up to 1 per ear per year. •Note: Includes 80 batteries per aid and 3 year warranty. •Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. - HER212
	• OTC Drugs and Supplies	•$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.-OTC305
	• Vision Services (Routine)	•100% after $15 copayment for routine exam (includes refraction) up to 1 per year. •$200 maximum benefit coverage amount for eyeglasses-frames up to 1 per year. •$120 maximum benefit coverage amount for premium progressive lenses up to 1 per year. •100% for eyeglasses-lenses or contact lenses up to 1 per year. - VIS001

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.		
Extra Benefits (MSB)	• SilverSneakers®	In most service areas members will have free membership to a local fitness center through the SilverSneakers® program.
	• Personal Health Coaching	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure manage and blood sugar management.
	• Smoking Cessation (Additional)	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.
	• Meal Program	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered their door at no cost.
	• Post-Discharge Transportation Services	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan appro locations by car, van or wheelchair accessible vehicle at no cost.
	• Post-Discharge Personal Home Care	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activit daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.
Care Management	• **Clinical Programs/Disease Management (3)** *- Case Management* *- Humana at Home®* *- Chronic Condition Management* *- Transplant Management* *- Behavioral Health Care Coordination*	Health education and clinical programs that provide support to members and caregivers to optimize health outcomes.

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a 'per visit' basis, unless otherwise noted.
(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.
(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.
2023 COVID-19 Testing and Treatment Update: Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. T products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regardin products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Extra Services (VAIS)	• Complementary and Alternative Medicine and Weight Management - Not available in Puerto Rico	Discounts for complementary and alternative medicine services including chiropractic, acupuncture, massage therapy and nutrition. Services must be received from participating designated providers.
	• Dental Discount (HumanaDental) - Not available in Florida or Puerto Rico	Discounts on dental services. Services must be received from participating HumanaDental providers.
	• Dental Discount (Careington Dental) - Available in Florida only	Discounts on dental services. Services must be received from participating Careington providers.
	• Healthy Hearing Discount (HearUSA) - Available in Florida only	Discounts on hearing aids, accessories and hearing assistance products.
	• Hearing Discount (TruHearing) - Not available in Florida or Puerto Rico	Discounts on hearing aids. Services must be received at a TruHearing hearing center.
	• Lifeline® Medical Alert Systems	Philips Lifeline may help members live independently with peace of mind. Personal emergency response services connect members caregivers and emergency services when an incident occurs. Wireless or landline options available.
	• Meal Delivery Discount	Discounts on home delivered meals to help support nutritional needs. Purchases may be placed online at MomsMeals.com/welldine calling 1.877.347.3438.
	• Vision Discount (EyeMed)	Discounts from participating EyeMed Vision Care Select network providers on routine vision services such as: Exam, contact lens fitt follow-up, lenses, frames and laser vision correction. Discounts are taken at point of sale. Discount and funded benefits cannot be u within the same transaction.

Rewards and Incentives by Humana is included in this plan:
Go365 is a wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help them establish and maintain a healthy lifestyle. As they achieve manageable health goals, Go365 ke members engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting and Annual Wellness Exam, or volunteering, members earn rewards they can redeem for gift car the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Members residing in some states can get coverage for most services without a referral or approval ahead of time from their PCP. 'Self-referred' means members get services on their own from network specialists. For a complete description of benefits, exclusions and limitations please to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

PERFORMANCE GUARANTEES

Humana's Group Medicare Performance Guarantee Agreement

Jefferson Parish Government

Group Medicare Advantage Proposed MA Only or MAPD
2023 Group Medicare Performance Standards
Minimum Annual Average Membership Requirement: **500**

PG #	Requested Category	Requested Amount at Risk	Humana's Recommended Category	Humana's Recommended Target	Humana's Recommended Standard & Measurement Criteria	Humana's Recommended Measurement, Reporting, and Assessment Frequency; Book-of-Business or Client specific	Humana's Recommended Annual Amount at Risk based on Minimum Annual Average Membership
IMPLEMENTATION							
1	**ID Cards -mailed within ten (10) business days after final member eligibility is received, system loaded and passes a quality assurance check. Measurement Criteria - Date ID cards are mailed.**	**$50,000**	**Ongoing ID Card Production and Distribution**	within 10 business days	Humana will agree that ongoing ID cards will be mailed to participants within 10 business days of receiving a Transaction Reply Report (TRR) acceptance from CMS or by the day prior to the members effective date. Humana follows CMS guidelines with regards to the production and distribution of member identification cards. Clean enrollment data is defined as the complete and accurate submission of the data elements required by CMS in an EDI file or paper application.	This metric will be reported quarterly for each effective year, measured and assessed annually following the end of the plan year. Based upon **client specific** results.	$50,000
CLAIMS ADMINISTRATION							
2	**Time to Pay- 90% of "non-controversial' or "clean" claims paid in ten (10) business days**	**$50,000 for failure to pay 90% of claims within 10 days; Increase $5,000 per extra day to meet 90% standard to a maximum of 15 days and maximum of $100,000.**	**Claims Turnaround Time**	90% of "non-controversial' or "clean" claims paid in ten (10) business days	Humana will agree to a Cycle Time of 90 % or greater in 10 business days, measured from the date a clean claim is received to the date it is "processed". Processed means paid or denied without requiring additional information from an external source. "Clean" is defined as needing no additional information from an external source.	This metric will be reported quarterly for each effective year, measured and assessed annually following the end of the plan year. Based upon **Humana's annual average book-of-business** results.	$50,000 for failure to pay 90% of claims within 10 business days; Increase $5,000 per extra business day to meet 90% standard to a maximum of 15 business days and maximum of $100,000.
3	**Financial Accuracy- 99% of submitted charges processed correctly**	**$100,000 for failure to process 99% of claims correctly; Increase $5,000 per 25% reduction in accuracy to 98% and maximum of $200,000**	**Financial Accuracy**	≥ 99%	Humana will agree to a Financial Accuracy rate of 99% or greater. Financial accuracy rate is defined as the percentage of dollars paid correctly. It is calculated by dividing the total claim dollars paid less the absolute value of overpayments and underpayments by the total claims dollars paid. Data is obtained through ongoing random audits.	This metric will be reported quarterly for each effective year, measured and assessed annually following the end of the plan year. Based upon **Humana's annual average book-of-business** results.	$100,000 for failure to process 99% of claims correctly; Increase $5,000 per 0.25% reduction in accuracy to 98% and maximum of $200,000
4	**Procedural Accuracy- 95% of claims processed without non-financial error**	**$20,000 for failure to process 95% of claims without a Non-financial error; increase $5,000 per .50% reduction in accuracy to 93% and maximum of $40,000.**	**Claims Processing Accuracy**	≥ 95%	Humana will agree to claim Processing Accuracy rate of 95% or greater. Processing accuracy is defined as the percentage of claims processed correctly. It is calculated by dividing the total number of correctly processed claims by the total number of claims paid.	This metric will be reported quarterly for each effective year, measured and assessed annually following the end of the plan year. Based upon **Humana's annual average book-of-business** results.	$20,000 for failure to process 95% of claims without a Non-financial error; increase $5,000 per 0.50% reduction in accuracy to 93% and maximum of $40,000.
CUSTOMER SERVICE							
5	**Eligibility Loading- Load all eligibility files into system within five (5) business days of receipt. Measurement Criteria- Elapsed time from date file received to the date upon which the file is loaded to the eligibility system.**	**$20,000**	**Eligibility Loads**	Within 5 business days of receipt	Humana will agree that clean eligibility files will be loaded into our system within 5 business days of receipt. Clean enrollment data is defined as the complete and accurate submission of the data elements required by CMS in an EDI file or paper application.	This metric is reported quarterly, measured per business day and assessed annually, based upon **client specific** results.	$20,000
						Total Amount at Risk:	**$410,000**

Humana agrees to meet the performance standards as outlined above while administering the Group Medicare Advantage Plan for **Jefferson Parish Government**. This agreement is contingent upon a minimum average enrollment with Humana of 500 members with Humana being the only Medicare Advantage option for Medicare eligible retirees. The agreement will be for the contract period beginning January 1, 2023 and ending December 31, 2023. As part of this agreement, Humana is willing to place an annual maximum at risk of $410,000 depending upon minimum average enrollment, for failure to meet the stated performance standards. This Performance Guarantee offering is based on an MA Only or MAPD plan offering. Performance results will be reported quarterly based upon center results for the member and claims services categories, not client specific results (except where otherwise stated) within 60 days after the end of the reporting period. Results will be assessed based on the annual results with payment of any penalties due following the end of the plan year. Please note that the performance standards are influenced by key market indicators (including changes in rules and standards from CMS) which could impact our performance standard metrics.

With respect to financial accuracy and processing accuracy, data is obtained through ongoing random audits based on a statistically valid sampling of all claims represented for payment.

During implementation if significant changes to the Client's Plan, or in the event a benefit change notification is not received from the Client on a timely basis, Humana will not be responsible for performance results or penalty amounts as described within this Agreement.

ACCEPTED AND AGREED:

By: _____ Date: _____
In order for this contract to be binding, signatures are required from the client. This signed exhibit must be returned to the Humana Account Executive prior to implementation and no later than 30 days post effective date.

NETWORK ACCESSIBILITY REPORT

Humana.

Humana Medicare Advantage PPO

Jefferson Parish Government

Created by...

Humana

August 17, 2022

Contents

Report Contents

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August 17, 2022

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Retiree locations

◆ With access

● Without access

Comparison Graph

Percent of retirees with access to a choice of providers over miles

1st closest

2nd closest

3rd closest

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

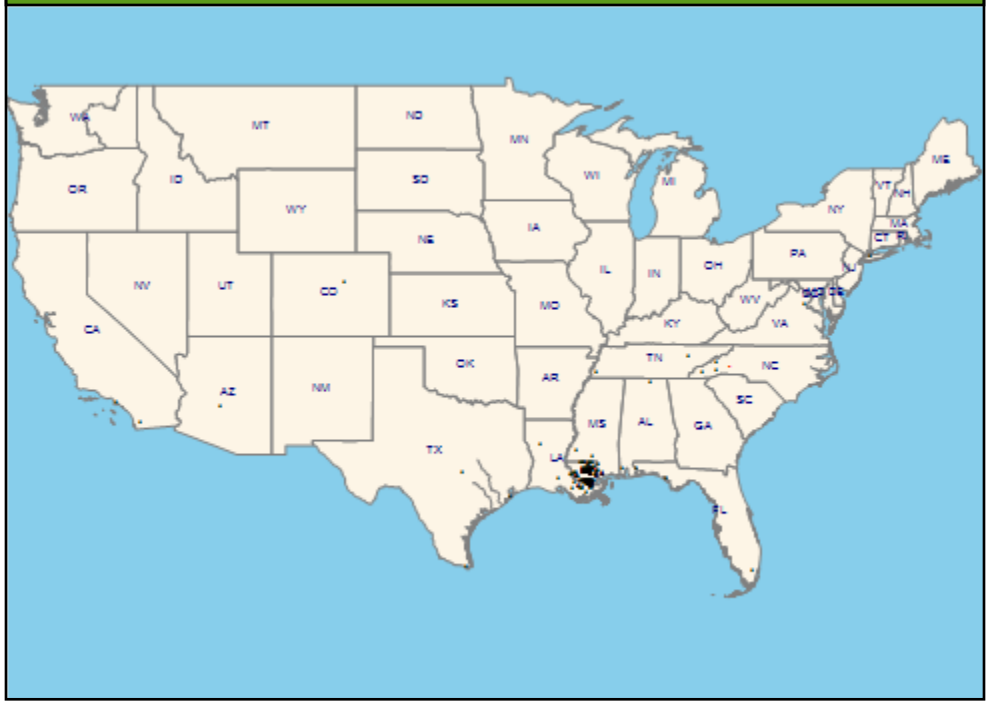
Overall Access[1]

740 Retirees
192,699 providers at 86,931 locations (Jefferson Parish Government)

733 (99.1%) Retirees with access

7 (0.9%) Retirees without access

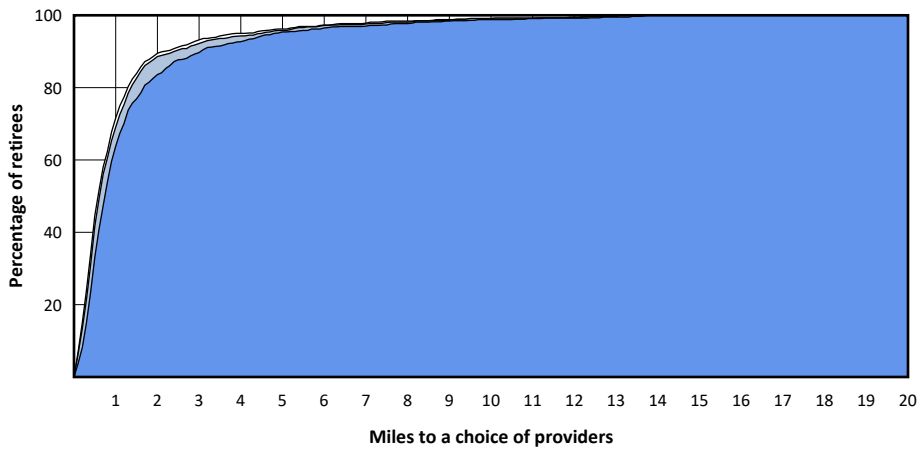
Retirees With and Without Access



Distances

	Average
Distance to 1st closest provider	1.1 miles
Distance to 2nd closest provider	1.2 miles
Distance to 3rd closest provider	1.4 miles

Access Standard Comparison



Access Summary By State Name

August 17, 2022

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Humana

Access Analysis

2 Primary Care Physicians in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Primary Care Physicians

Areas With Access

Top 35 State Names in the market, sorted by the number of retirees with access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees With Access

Retiree Group	**740 retirees** 733 (99.1%) retirees with access	Provider Group	**192,699 unique providers at 86,931 unique locations** (308,174 total access points)

Key Geographic Areas

	State Name	Retiree	With Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
With Access	Louisiana	710	704	99.2	7,565	1.0	1.1	1.3
	Mississippi	10	10	100.0	4,145	2.2	2.4	2.4
	Florida	3	3	100.0	12,895	1.3	2.6	3.0
	North Carolina	4	3	75.0	13,939	0.3	0.4	2.3
	Texas	3	3	100.0	21,617	1.1	1.2	1.3
	Alabama	2	2	100.0	5,667	1.8	1.9	2.1
	California	2	2	100.0	5,389	0.4	1.3	1.3
	Tennessee	2	2	100.0	9,351	2.3	2.3	2.8
	Arizona	1	1	100.0	7,129	0.9	1.6	1.6
	Colorado	1	1	100.0	4,558	2.0	2.0	2.0
	New York	1	1	100.0	18,275	0.6	0.6	0.6
	Virginia	1	1	100.0	8,296	0.2	1.3	1.3

Access Detail By County

August 17, 2022

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Humana

Access Analysis

2 Primary Care Physicians in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Primary Care Physicians

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alabama	Madison	1	484	1	100.0	2.2	2.3	2.3
	Mobile	1	573	1	100.0	1.4	1.4	1.8
Arizona	Maricopa	1	3,894	1	100.0	0.9	1.6	1.6
California	Los Angeles	1	1,167	1	100.0	0.7	0.7	0.7
	San Diego	1	706	1	100.0	0.1	1.8	1.8
Colorado	Douglas	1	271	1	100.0	2.0	2.0	2.0
Florida	Bay	1	99	1	100.0	1.6	3.2	3.2
	Escambia	1	255	1	100.0	0.9	3.3	4.4
	Miami-Dade	1	1,091	1	100.0	1.3	1.3	1.3
Louisiana	Ascension	5	104	5	100.0	1.9	2.0	2.0
	Assumption	1	27	1	100.0	0.4	0.4	0.4
	East Baton Rouge	2	814	2	100.0	1.4	1.4	1.4
	Jefferson	538	799	538	100.0	0.7	0.7	0.9
	Lafayette	1	441	1	100.0	0.5	0.5	0.5
	Lafourche	6	80	6	100.0	1.3	2.5	2.6
	Livingston	3	88	3	100.0	4.3	4.9	4.9
	Natchitoches	1	58	1	100.0	0.5	0.5	0.9
	Orleans	24	656	24	100.0	0.7	0.8	0.9
	Plaquemines	3	17	3	100.0	1.3	1.4	3.7
	St. Charles	9	63	9	100.0	0.9	0.9	1.3
	St. Helena	1	24	1	100.0	4.4	4.4	4.5
	St. James	2	24	2	100.0	0.2	0.2	0.3
	St. John the Baptist	10	39	10	100.0	1.3	1.3	1.3
	St. Mary	1	58	1	100.0	0.7	0.7	0.7
	St. Tammany	71	329	65	91.5	2.6	2.7	3.0
	Tangipahoa	23	225	23	100.0	2.7	2.9	3.1
	Terrebonne	1	96	1	100.0	2.6	2.6	2.8
	Washington	7	116	7	100.0	2.6	3.5	3.5
	West Baton Rouge	1	17	1	100.0	3.9	4.0	4.1
Mississippi	Franklin	1	11	1	100.0	0.4	0.4	0.9
	Hancock	5	53	5	100.0	2.1	2.3	2.4
	Marion	1	30	1	100.0	7.4	7.4	7.4
	Pearl River	3	56	3	100.0	1.3	1.3	1.4
New York	Nassau	1	2,001	1	100.0	0.6	0.6	0.6
North Carolina	Buncombe	1	509	1	100.0	0.4	0.4	0.4
	Henderson	1	190	1	100.0	0.4	0.6	6.4
	Macon	1	96	1	100.0	0.1	0.1	0.1
Tennessee	Anderson	1	99	1	100.0	1.7	1.7	1.7
	Shelby	1	1,017	1	100.0	2.8	2.8	3.9
Texas	Cameron	1	272	1	100.0	1.4	1.6	1.9

Continued on next page...

Access Detail By County

August 17, 2022

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Access Analysis

2 Primary Care Physicians in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Primary Care Physicians

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Texas	Galveston	1	416	1	100.0	0.4	0.4	0.4
	Travis	1	964	1	100.0	1.6	1.6	1.6
Virginia	Stafford	1	71	1	100.0	0.2	1.3	1.3
Grand Totals		**739**	**18,400**	**733**	**99.2**	**1.0**	**1.1**	**1.3**

Access Summary By State Name

August 17, 2022

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Humana

Access Analysis

2 Primary Care Physicians in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Primary Care Physicians

Areas Without Access

Bottom 35 State Names in the market, sorted by the number of retirees without access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees Without Access

Retiree Group	**740 retirees** 7 (0.9%) retirees without access	Provider Group	**192,699 unique providers at 86,931 unique locations** (308,174 total access points)

Key Geographic Areas

	State Name	Retiree	Without Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
Without Access	Louisiana	710	6	0.8	7,565	12.3	12.3	12.9
	North Carolina	4	1	25.0	13,939	11.1	12.4	12.4

Access Detail By County

August 17, 2022

Created by...

Humana

Access Analysis

2 Primary Care Physicians in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Primary Care Physicians

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

Retirees Without Access								
State Name	County	Retiree Counts		Without Access[1]		Average Distance		
		#	#	#	%	1	2	3
Louisiana	St. Tammany	71	329	6	8.5	12.3	12.3	12.9
North Carolina	Rutherford	1	53	1	100.0	11.1	12.4	12.4
Grand Totals		**72**	**382**	**7**	**9.7**	**12.1**	**12.3**	**12.9**

Access Overview

August 17, 2022

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Humana

Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

Access Map

Retiree locations

◆ With access

● Without access

Comparison Graph

Percent of retirees with access to a choice of providers over miles

1st closest

2nd closest

3rd closest

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

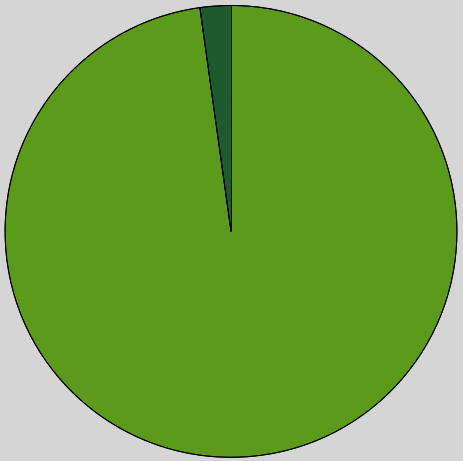
2 (Specialists) providers in 10 miles

Overall Access[1]

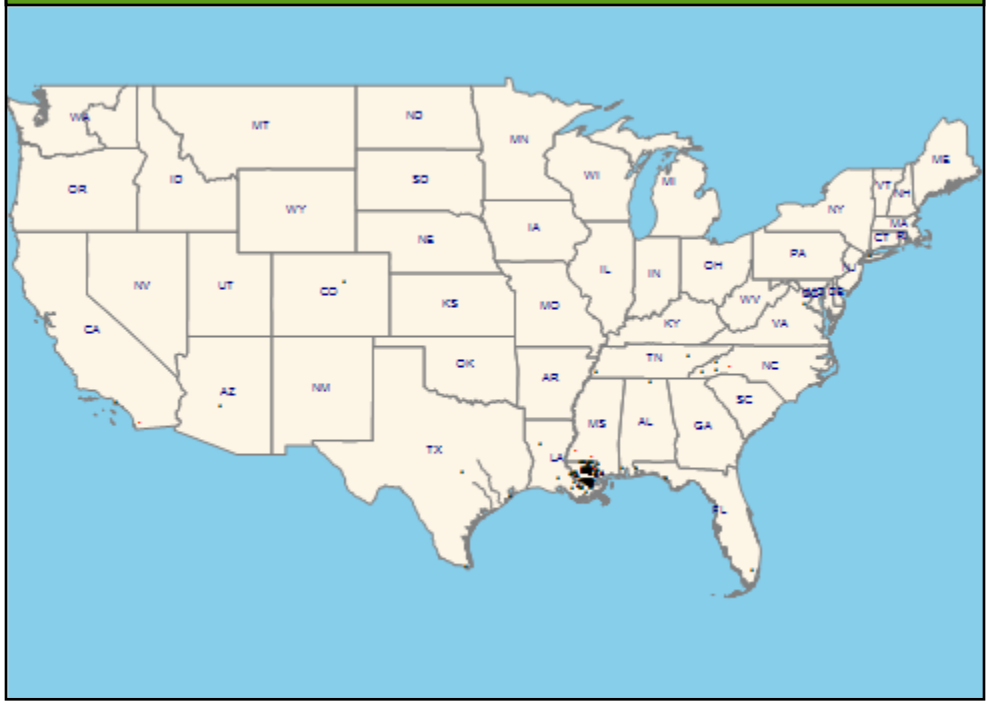
740 Retirees
390,952 providers at 129,512 locations (Jefferson Parish Government)

724 (97.8%) Retirees with access

16 (2.2%) Retirees without access



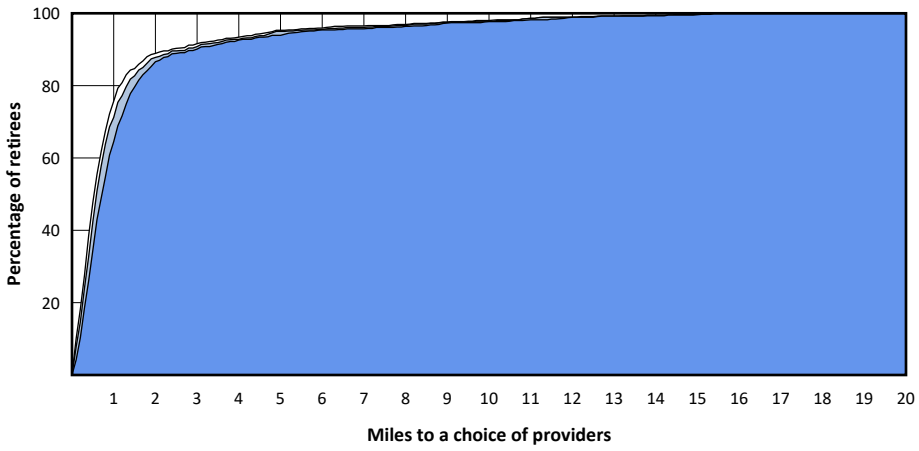
Retirees With and Without Access



Distances

	Average
Distance to 1st closest provider	1.2 miles
Distance to 2nd closest provider	1.3 miles
Distance to 3rd closest provider	1.5 miles

Access Standard Comparison



Access Summary By State Name

August 17, 2022

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Access Analysis
2 Specialists in 10 miles

Retiree Group
Jefferson Parish Government

Provider Group
Specialists

Areas With Access
Top 35 State Names in the market, sorted by the number of retirees with access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:
2 (Specialists) providers in 10 miles

[2] Provider counts represent:
#: Provider access points

Retirees With Access

Retiree Group	**740 retirees** 724 (97.8%) retirees with access	Provider Group	**390,952 unique providers at 129,512 unique locations** (956,669 total access points)

Key Geographic Areas

	State Name	Retiree	With Access[1]		Counts[2]	Average Distance	
		#	#	%	#	1	2
With Access	Louisiana	710	698	98.3	20,405	1.0	1.0
	Mississippi	10	8	80.0	5,821	1.9	2.2
	Florida	3	3	100.0	41,836	2.4	2.7
	North Carolina	4	3	75.0	45,898	2.1	2.4
	Texas	3	3	100.0	111,578	0.7	0.7
	Alabama	2	2	100.0	11,738	2.1	2.1
	Tennessee	2	2	100.0	23,206	1.4	1.6
	Arizona	1	1	100.0	18,338	0.5	0.5
	California	2	1	50.0	18,303	0.5	0.6
	Colorado	1	1	100.0	21,079	2.0	2.0
	New York	1	1	100.0	62,530	0.5	0.5
	Virginia	1	1	100.0	27,061	0.2	0.2

Access Detail By County

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alabama	Madison	1	1,130	1	100.0	3.5	3.5	3.5
	Mobile	1	1,890	1	100.0	0.7	0.7	0.7
Arizona	Maricopa	1	11,332	1	100.0	0.5	0.5	1.3
California	Los Angeles	1	3,342	1	100.0	0.5	0.6	0.6
Colorado	Douglas	1	1,598	1	100.0	2.0	2.0	2.0
Florida	Bay	1	272	1	100.0	4.0	4.8	4.8
	Escambia	1	1,073	1	100.0	1.8	1.8	1.8
	Miami-Dade	1	4,177	1	100.0	1.4	1.4	1.4
Louisiana	Ascension	5	197	5	100.0	1.8	1.8	2.1
	Assumption	1	21	1	100.0	1.9	1.9	1.9
	East Baton Rouge	2	2,881	2	100.0	1.1	1.1	1.1
	Jefferson	538	2,922	538	100.0	0.6	0.7	0.8
	Lafayette	1	1,365	1	100.0	0.4	0.4	0.4
	Lafourche	6	343	6	100.0	2.0	2.1	2.2
	Livingston	3	183	3	100.0	5.3	5.9	6.0
	Natchitoches	1	141	1	100.0	0.5	0.5	0.5
	Orleans	24	2,360	24	100.0	0.7	0.8	1.0
	Plaquemines	3	9	3	100.0	1.8	1.8	2.6
	St. Charles	9	190	9	100.0	1.1	1.2	2.3
	St. Helena	1	18	1	100.0	4.4	4.4	4.4
	St. James	2	31	2	100.0	0.3	1.0	1.0
	St. John the Baptist	10	110	10	100.0	1.3	1.6	1.8
	St. Mary	1	103	1	100.0	0.5	0.5	0.5
	St. Tammany	71	1,677	59	83.1	2.2	2.4	2.6
	Tangipahoa	23	551	23	100.0	3.5	3.6	4.0
	Terrebonne	1	389	1	100.0	2.8	2.8	2.8
	Washington	7	301	7	100.0	3.5	3.7	3.7
	West Baton Rouge	1	21	1	100.0	3.4	3.4	3.4
Mississippi	Hancock	5	76	5	100.0	2.1	2.4	2.5
	Pearl River	3	73	3	100.0	1.6	1.7	2.1
New York	Nassau	1	9,673	1	100.0	0.5	0.5	0.6
North Carolina	Buncombe	1	1,140	1	100.0	0.4	0.4	0.4
	Henderson	1	344	1	100.0	5.7	6.4	6.4
	Macon	1	345	1	100.0	0.3	0.3	0.5
Tennessee	Anderson	1	271	1	100.0	1.1	1.1	1.1
	Shelby	1	3,724	1	100.0	1.6	2.0	2.0
Texas	Cameron	1	931	1	100.0	0.5	0.5	0.5
	Galveston	1	1,254	1	100.0	1.0	1.0	1.4
	Travis	1	5,896	1	100.0	0.6	0.6	0.6
Virginia	Stafford	1	232	1	100.0	0.2	0.2	0.2

Continued on next page...

Access Detail By County

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Grand Totals		**736**	**62,586**	**724**	**98.4**	**1.0**	**1.1**	**1.2**

Access Summary By State Name

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Specialists

Areas Without Access

Bottom 35 State Names in the market, sorted by the number of retirees without access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees Without Access

Retiree Group	**740 retirees** 16 (2.2%) retirees without access	Provider Group	**390,952 unique providers at 129,512 unique locations** (956,669 total access points)

Key Geographic Areas

	State Name	Retiree	Without Access [1]		Counts [2]	Average Distance	
		#	#	%	#	1	2
Without Access	Louisiana	710	12	1.7	20,405	12.1	12.3
	Mississippi	10	2	20.0	5,821	18.1	18.2
	California	2	1	50.0	18,303	1.8	10.8
	North Carolina	4	1	25.0	45,898	13.2	13.8

Access Detail By County

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

Retirees Without Access								
State Name	County	Retiree Counts		Without Access[1]		Average Distance		
		#	#	#	%	1	2	3
California	San Diego	1	3,479	1	100.0	1.8	10.8	10.9
Louisiana	St. Tammany	71	1,677	12	16.9	12.1	12.3	12.7
Mississippi	Franklin	1	0	1	100.0	23.5	23.7	23.8
	Marion	1	16	1	100.0	12.6	12.6	12.6
North Carolina	Rutherford	1	97	1	100.0	13.2	13.8	13.8
Grand Totals		**75**	**5,269**	**16**	**21.3**	**12.3**	**13.1**	**13.4**

Access Overview

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Hospitals

Access Map

Retiree locations

◆ With access

● Without access

Comparison Graph

Percent of retirees with access to a choice of providers over miles

1st closest

2nd closest

3rd closest

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

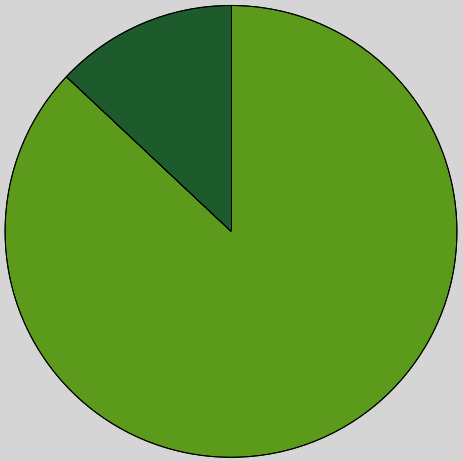
2 (Hospitals) providers in 10 miles

Overall Access[1]

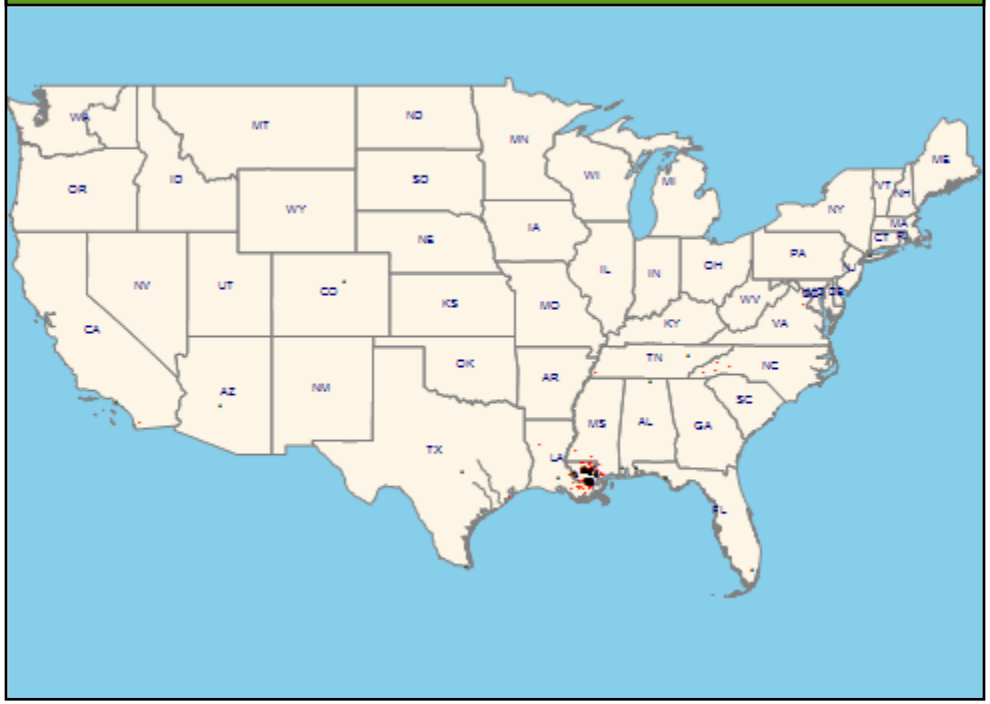
740 Retirees
4,043 providers at 4,302 locations (Jefferson Parish Government)

644 (87.0%) Retirees with access

96 (13.0%) Retirees without access



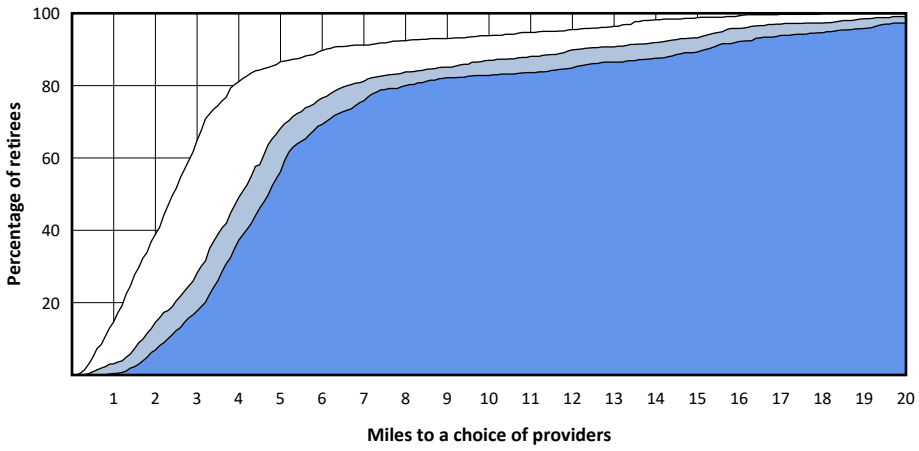
Retirees With and Without Access



Distances

	Average
Distance to 1st closest provider	3.3 miles
Distance to 2nd closest provider	5.4 miles
Distance to 3rd closest provider	6.5 miles

Access Standard Comparison



Access Summary By State Name

August 17, 2022

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Access Analysis
2 Hospitals in 10 miles

Retiree Group
Jefferson Parish Government

Provider Group
Hospitals

Areas With Access
Top 35 State Names in the market, sorted by the number of retirees with access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:
2 (Hospitals) providers in 10 miles

[2] Provider counts represent:
#: Provider access points

Retirees With Access

Retiree Group	740 retirees 644 (87.0%) retirees with access	Provider Group	4,043 unique providers at 4,302 unique locations (4,459 total access points)

Key Geographic Areas

	State Name	Retiree	With Access[1]		Counts[2]	Average Distance	
		#	#	%	#	1	2
With Access	Louisiana	710	632	89.0	133	2.4	3.9
	Florida	3	3	100.0	269	4.9	6.9
	Alabama	2	2	100.0	97	5.9	7.9
	Texas	3	2	66.7	423	2.3	4.4
	Arizona	1	1	100.0	93	4.4	4.4
	California	2	1	50.0	99	2.8	3.0
	Colorado	1	1	100.0	68	5.9	9.6
	New York	1	1	100.0	310	0.6	0.6
	Tennessee	2	1	50.0	117	2.1	2.3

Access Detail By County

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Hospitals

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Hospitals) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alabama	Madison	1	5	1	100.0	5.6	5.8	5.9
	Mobile	1	5	1	100.0	6.1	9.9	13.3
Arizona	Maricopa	1	55	1	100.0	4.4	4.4	4.5
California	Los Angeles	1	34	1	100.0	2.8	3.0	8.1
Colorado	Douglas	1	4	1	100.0	5.9	9.6	15.5
Florida	Bay	1	2	1	100.0	4.9	7.6	38.3
	Escambia	1	4	1	100.0	6.0	8.9	11.9
	Miami-Dade	1	21	1	100.0	3.8	4.2	9.6
Louisiana	Ascension	5	3	3	60.0	3.7	7.2	13.9
	East Baton Rouge	2	11	2	100.0	2.9	3.1	3.8
	Jefferson	538	10	531	98.7	2.3	3.7	4.3
	Lafayette	1	8	1	100.0	1.2	1.8	1.9
	Orleans	24	5	23	95.8	2.8	4.1	5.7
	Plaquemines	3	0	2	66.7	3.9	8.2	8.4
	St. Charles	9	1	5	55.6	5.3	7.9	9.6
	St. Tammany	71	8	48	67.6	2.8	4.8	5.2
	Tangipahoa	23	4	16	69.6	4.2	7.1	13.4
	Washington	7	3	1	14.3	1.3	1.8	19.3
New York	Nassau	1	32	1	100.0	0.6	0.6	3.8
Tennessee	Anderson	1	2	1	100.0	2.1	2.3	12.8
Texas	Cameron	1	4	1	100.0	2.8	5.8	24.0
	Travis	1	15	1	100.0	1.7	3.0	5.0
Grand Totals		**695**	**236**	**644**	**92.7**	**2.4**	**3.9**	**4.9**

Access Summary By State Name

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Hospitals

Areas Without Access

Bottom 35 State Names in the market, sorted by the number of retirees without access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Hospitals) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees Without Access

Retiree Group	740 retirees 96 (13.0%) retirees without access	Provider Group	4,043 unique providers at 4,302 unique locations (4,459 total access points)

Key Geographic Areas

	State Name	Retiree	Without Access [1]		Counts [2]	Average Distance	
		#	#	%	#	1	2
Without Access	Louisiana	710	78	11.0	133	9.3	14.8
	Mississippi	10	10	100.0	81	4.2	18.8
	North Carolina	4	4	100.0	125	8.7	18.8
	California	2	1	50.0	99	26.7	27.0
	Tennessee	2	1	50.0	117	9.1	11.9
	Texas	3	1	33.3	423	5.2	16.7
	Virginia	1	1	100.0	104	2.3	13.1

Access Detail By County

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Hospitals

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Hospitals) providers in 10 miles

Retirees Without Access								
State Name	County	Retiree Counts		Without Access[1]		Average Distance		
		#	#	#	%	1	2	3
California	San Diego	1	3	1	100.0	26.7	27.0	28.6
Louisiana	Ascension	5	3	2	40.0	5.2	10.7	17.1
	Assumption	1	1	1	100.0	1.9	11.3	22.4
	Jefferson	538	10	7	1.3	10.5	12.8	13.2
	Lafourche	6	3	6	100.0	3.5	17.3	20.0
	Livingston	3	0	3	100.0	8.6	14.4	16.2
	Natchitoches	1	1	1	100.0	1.0	30.7	32.3
	Orleans	24	5	1	4.2	6.1	12.0	16.4
	Plaquemines	3	0	1	33.3	11.2	15.4	15.9
	St. Charles	9	1	4	44.4	2.3	12.7	13.5
	St. Helena	1	1	1	100.0	4.4	16.7	23.8
	St. James	2	1	2	100.0	1.0	19.1	22.9
	St. John the Baptist	10	0	10	100.0	13.5	14.9	16.1
	St. Mary	1	2	1	100.0	18.0	24.7	24.8
	St. Tammany	71	8	23	32.4	12.2	14.3	15.3
	Tangipahoa	23	4	7	30.4	10.8	12.8	16.9
	Terrebonne	1	2	1	100.0	3.2	12.5	15.2
	Washington	7	3	6	85.7	6.3	17.6	18.9
	West Baton Rouge	1	0	1	100.0	10.8	11.7	12.2
Mississippi	Franklin	1	1	1	100.0	0.4	29.9	31.5
	Hancock	5	1	5	100.0	3.7	17.2	17.6
	Marion	1	1	1	100.0	14.2	14.4	27.0
	Pearl River	3	2	3	100.0	3.1	19.3	20.1
North Carolina	Buncombe	1	1	1	100.0	10.1	24.4	29.5
	Henderson	1	2	1	100.0	7.7	10.2	11.2
	Macon	1	2	1	100.0	0.8	16.9	19.3
	Rutherford	1	1	1	100.0	16.2	23.6	24.2
Tennessee	Shelby	1	12	1	100.0	9.1	11.9	15.1
Texas	Galveston	1	3	1	100.0	5.2	16.7	28.1
Virginia	Stafford	1	1	1	100.0	2.3	13.1	18.3
Grand Totals		**725**	**75**	**96**	**13.2**	**8.8**	**15.5**	**17.5**

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Medicare Advantage HMO

Jefferson Parish Government

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August 17, 2022

Contents

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August 17, 2022

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2 Primary Care Physicians in 10 miles

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Jefferson Parish Government

Primary Care Physicians

Access Map

Retiree locations

- With access
- Without access

Retiree locations

- All Retirees

Service areas:

- Medicare Advantage HMO

678.29 miles

Comparison Graph

Percent of retirees with access to a choice of providers over miles

- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

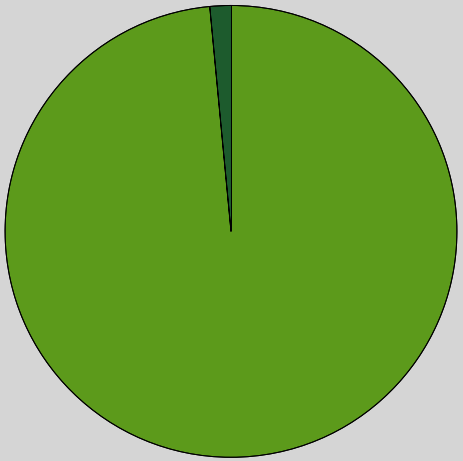
2 (Primary Care Physicians) providers in 10 miles

Overall Access[1]

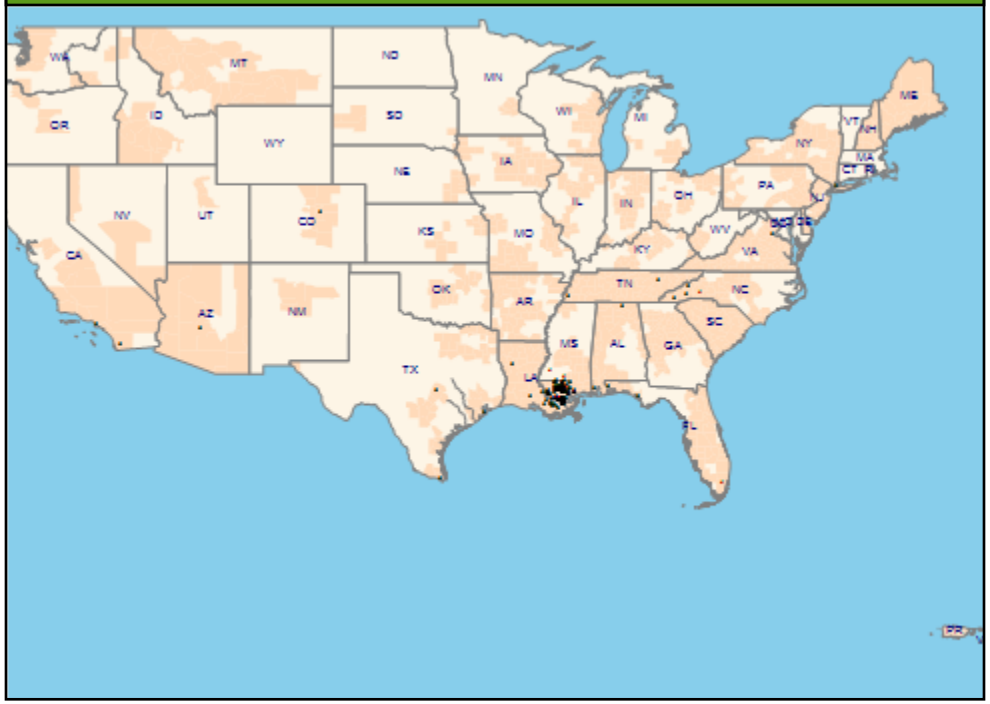
740 Retirees
212,630 providers at 58,981 locations (Jefferson Parish Government)

729 (98.5%) Retirees with access

11 (1.5%) Retirees without access



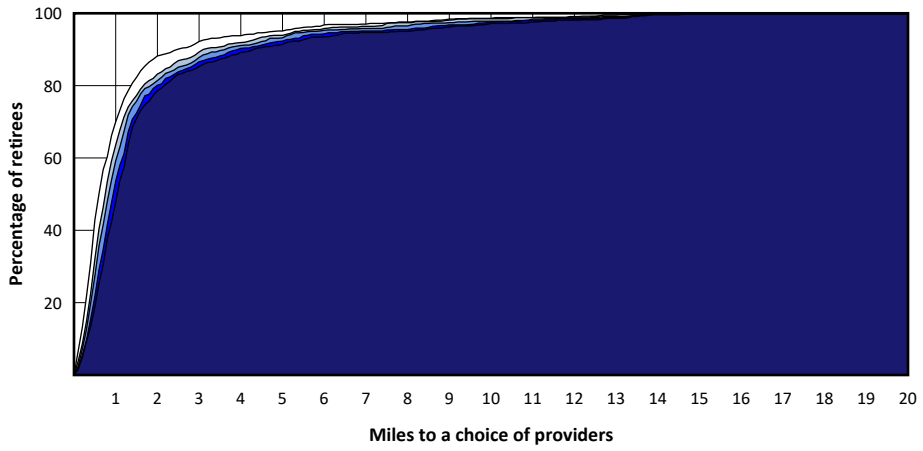
All Employees



Distances

	Average
Distance to 1st closest provider	1.3 miles
Distance to 2nd closest provider	1.6 miles
Distance to 3rd closest provider	1.7 miles
Distance to 4th closest provider	1.9 miles
Distance to 5th closest provider	2.0 miles

Access Standard Comparison



Access Summary By State Name

August 17, 2022

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Access Analysis

2 Primary Care Physicians in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Primary Care Physicians

Areas With Access

Top 35 State Names in the market, sorted by the number of retirees with access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees With Access

Retiree Group	740 retirees 729 (98.5%) retirees with access	Provider Group	212,630 unique providers at 58,981 unique locations (212,630 total access points)

Key Geographic Areas

	State Name	Retiree	With Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
With Access	Louisiana	710	703	99.0	5,259	1.1	1.3	1.4
	Mississippi	10	8	80.0	1,554	2.0	2.0	2.1
	North Carolina	4	3	75.0	11,934	0.5	2.4	2.4
	Texas	3	3	100.0	11,894	1.1	1.1	1.2
	Alabama	2	2	100.0	3,087	1.8	2.1	2.1
	California	2	2	100.0	10,368	1.1	1.2	5.8
	Florida	3	2	66.7	4,645	2.5	4.5	4.9
	Tennessee	2	2	100.0	6,275	3.6	4.6	4.9
	Arizona	1	1	100.0	4,143	1.6	1.6	1.7
	Colorado	1	1	100.0	2,945	2.0	2.0	2.0
	New York	1	1	100.0	16,188	0.6	0.6	0.6
	Virginia	1	1	100.0	7,157	1.3	1.3	1.3

Access Detail By County

August 17, 2022

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Access Analysis

2 Primary Care Physicians in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Primary Care Physicians

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alabama	Madison	1	384	1	100.0	2.2	2.3	2.3
	Mobile	1	513	1	100.0	1.4	1.8	1.8
Arizona	Maricopa	1	2,708	1	100.0	1.6	1.6	1.7
California	Los Angeles	1	4,372	1	100.0	0.3	0.5	0.6
	San Diego	1	1,055	1	100.0	1.8	1.8	11.0
Colorado	Douglas	1	228	1	100.0	2.0	2.0	2.0
Florida	Bay	1	54	1	100.0	3.2	4.5	4.5
	Escambia	1	153	1	100.0	1.8	4.4	5.2
Louisiana	Ascension	5	82	5	100.0	1.9	2.0	2.1
	Assumption	1	12	1	100.0	0.4	1.7	1.9
	East Baton Rouge	2	724	2	100.0	1.4	1.4	1.8
	Jefferson	538	761	538	100.0	0.7	0.9	1.0
	Lafayette	1	313	1	100.0	0.5	0.9	1.0
	Lafourche	6	55	6	100.0	1.6	2.5	2.9
	Livingston	3	46	3	100.0	5.9	6.0	7.1
	Natchitoches	1	24	1	100.0	0.5	0.9	1.0
	Orleans	24	675	24	100.0	0.7	0.9	1.0
	Plaquemines	3	10	3	100.0	1.4	3.7	3.7
	St. Charles	9	43	9	100.0	1.4	1.8	1.9
	St. Helena	1	5	1	100.0	4.4	4.5	4.5
	St. James	2	11	2	100.0	0.2	0.2	0.3
	St. John the Baptist	10	23	10	100.0	1.3	1.4	1.4
	St. Mary	1	25	1	100.0	1.3	1.3	1.3
	St. Tammany	71	285	65	91.5	2.6	2.7	3.1
	Tangipahoa	23	106	23	100.0	3.5	4.2	4.6
	Terrebonne	1	67	1	100.0	2.6	2.8	2.8
	Washington	7	71	6	85.7	1.7	2.7	3.5
	West Baton Rouge	1	4	1	100.0	4.1	5.5	5.7
Mississippi	Hancock	5	45	5	100.0	2.3	2.4	2.5
	Pearl River	3	32	3	100.0	1.3	1.3	1.4
New York	Nassau	1	2,404	1	100.0	0.6	0.6	0.6
North Carolina	Buncombe	1	459	1	100.0	0.4	0.4	0.4
	Henderson	1	164	1	100.0	0.6	6.4	6.4
	Macon	1	62	1	100.0	0.4	0.4	0.4
Tennessee	Anderson	1	59	1	100.0	1.7	1.7	1.7
	Shelby	1	868	1	100.0	5.4	7.5	8.1
Texas	Cameron	1	83	1	100.0	1.2	1.2	1.6
	Galveston	1	469	1	100.0	0.3	0.3	0.3
	Travis	1	757	1	100.0	1.7	1.7	1.7
Virginia	Stafford	1	56	1	100.0	1.3	1.3	1.3

Continued on next page...

Access Detail By County

August 17, 2022

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Access Analysis

2 Primary Care Physicians in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Primary Care Physicians

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Grand Totals		**736**	**18,267**	**729**	**99.0**	**1.1**	**1.3**	**1.4**

Access Summary By State Name

August 17, 2022

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Access Analysis

2 Primary Care Physicians in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Primary Care Physicians

Areas Without Access

Bottom 35 State Names in the market, sorted by the number of retirees without access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees Without Access

Retiree Group	**740 retirees** 11 (1.5%) retirees without access	Provider Group	**212,630 unique providers at 58,981 unique locations** (212,630 total access points)

Key Geographic Areas

	State Name	Retiree	Without Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
Without Access	Louisiana	710	7	1.0	5,259	11.8	12.2	12.8
	Mississippi	10	2	20.0	1,554	18.0	19.1	20.6
	Florida	3	1	33.3	4,645	68.9	68.9	68.9
	North Carolina	4	1	25.0	11,934	11.1	12.4	12.4

Access Detail By County

August 17, 2022

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Access Analysis

2 Primary Care Physicians in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Primary Care Physicians

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Primary Care Physicians) providers in 10 miles

Retirees Without Access								
State Name	County	Retiree Counts		Without Access[1]		Average Distance		
		#	#	#	%	1	2	3
Florida	Miami-Dade	1	0	1	100.0	68.9	68.9	68.9
Louisiana	St. Tammany	71	285	6	8.5	12.3	12.5	12.9
	Washington	7	71	1	14.3	8.6	10.5	12.2
Mississippi	Franklin	1	0	1	100.0	23.4	25.5	28.6
	Marion	1	11	1	100.0	12.6	12.6	12.6
North Carolina	Rutherford	1	40	1	100.0	11.1	12.4	12.4
Grand Totals		**82**	**407**	**11**	**13.4**	**18.0**	**18.6**	**19.3**

Access Overview

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

Access Map

Retiree locations

◆ With access

● Without access

Retiree locations

◆ All Retirees

Service areas:

Medicare Advantage HMO

678.29 miles

Comparison Graph

Percent of retirees with access to a choice of providers over miles

1st closest

2nd closest

3rd closest

4th closest

5th closest

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

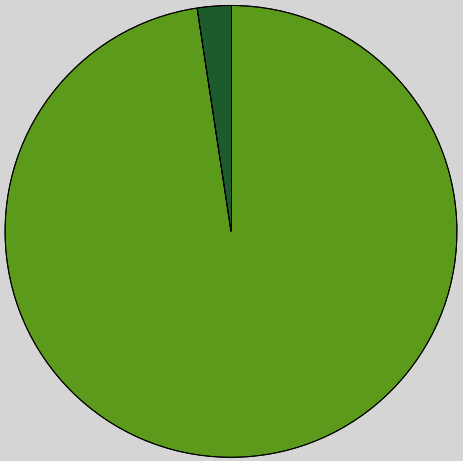
2 (Specialists) providers in 10 miles

Overall Access[1]

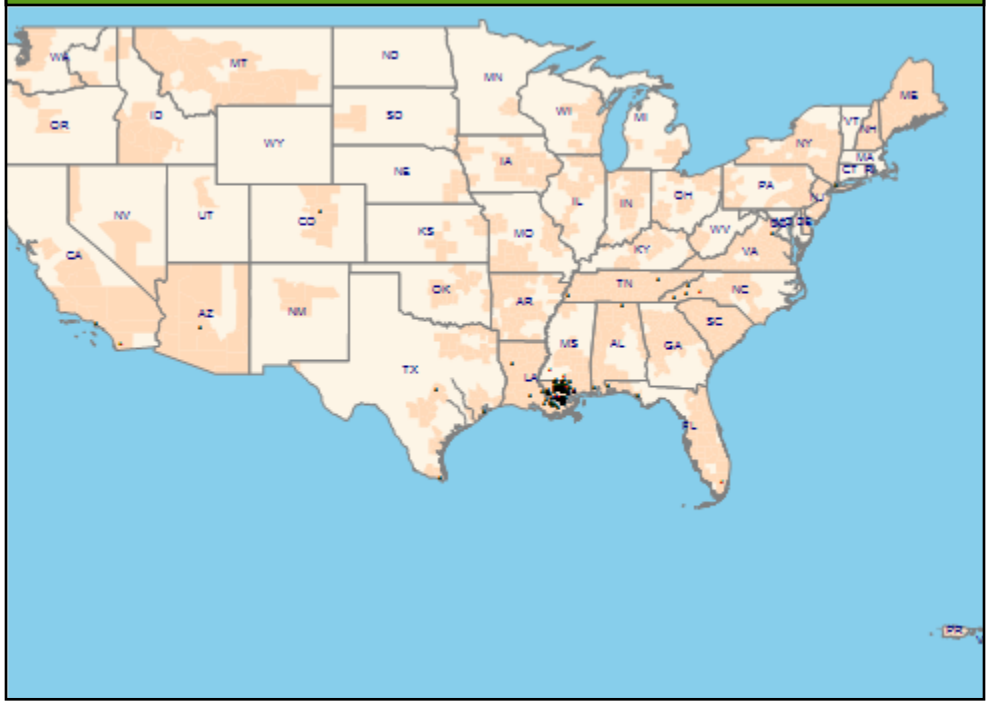
740 Retirees
705,971 providers at 91,347 locations (Jefferson Parish Government)

722 (97.6%) Retirees with access

18 (2.4%) Retirees without access



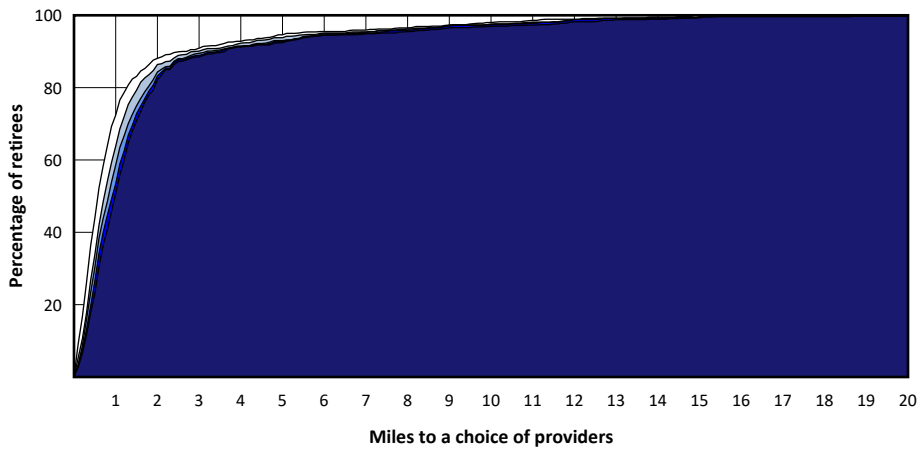
All Employees



Distances

	Average
Distance to 1st closest provider	1.3 miles
Distance to 2nd closest provider	1.6 miles
Distance to 3rd closest provider	1.7 miles
Distance to 4th closest provider	1.8 miles
Distance to 5th closest provider	1.9 miles

Access Standard Comparison



Access Summary By State Name

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Specialists

Areas With Access

Top 35 State Names in the market, sorted by the number of retirees with access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees With Access

Retiree Group	**740 retirees** 722 (97.6%) retirees with access	Provider Group	**705,971 unique providers at 91,347 unique locations** (705,971 total access points)

Key Geographic Areas

	State Name	Retiree	With Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
With Access	Louisiana	710	697	98.2	16,953	1.0	1.2	1.3
	Mississippi	10	8	80.0	4,244	2.2	3.0	3.0
	North Carolina	4	3	75.0	41,955	2.2	2.2	2.2
	Texas	3	3	100.0	76,238	0.8	0.9	1.3
	Alabama	2	2	100.0	8,194	2.1	2.1	2.1
	Florida	3	2	66.7	19,767	3.3	3.3	3.3
	Tennessee	2	2	100.0	19,278	1.4	2.0	2.0
	Arizona	1	1	100.0	14,626	0.5	0.5	0.5
	California	2	1	50.0	22,213	0.4	0.6	0.6
	Colorado	1	1	100.0	16,978	2.0	2.0	2.0
	New York	1	1	100.0	55,736	0.6	0.6	0.6
	Virginia	1	1	100.0	22,694	1.0	1.5	1.5

Access Detail By County

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alabama	Madison	1	958	1	100.0	3.5	3.5	3.5
	Mobile	1	1,587	1	100.0	0.7	0.7	0.7
Arizona	Maricopa	1	10,010	1	100.0	0.5	0.5	0.5
California	Los Angeles	1	7,188	1	100.0	0.4	0.6	0.6
Colorado	Douglas	1	1,491	1	100.0	2.0	2.0	2.0
Florida	Bay	1	185	1	100.0	4.8	4.8	4.8
	Escambia	1	832	1	100.0	1.8	1.8	1.8
Louisiana	Ascension	5	139	5	100.0	1.8	1.8	2.0
	Assumption	1	17	1	100.0	1.9	1.9	1.9
	East Baton Rouge	2	2,471	2	100.0	1.1	1.3	1.3
	Jefferson	538	2,627	538	100.0	0.7	0.8	0.9
	Lafayette	1	1,079	1	100.0	0.4	0.4	0.4
	Lafourche	6	275	6	100.0	2.0	2.1	2.7
	Livingston	3	128	3	100.0	6.1	6.1	6.1
	Natchitoches	1	113	1	100.0	0.9	0.9	0.9
	Orleans	24	2,140	24	100.0	0.9	1.0	1.1
	Plaquemines	3	5	3	100.0	1.8	2.2	4.8
	St. Charles	9	179	9	100.0	0.9	2.2	2.6
	St. Helena	1	13	1	100.0	4.4	4.4	4.4
	St. James	2	24	2	100.0	0.3	1.0	1.0
	St. John the Baptist	10	97	10	100.0	1.4	1.4	1.5
	St. Mary	1	79	1	100.0	0.5	0.5	1.1
	St. Tammany	71	1,391	58	81.7	2.2	2.5	2.6
	Tangipahoa	23	450	23	100.0	3.9	4.0	4.0
	Terrebonne	1	321	1	100.0	2.8	2.8	2.8
	Washington	7	283	7	100.0	3.7	3.8	3.8
	West Baton Rouge	1	12	1	100.0	3.5	3.9	3.9
Mississippi	Hancock	5	60	5	100.0	2.5	2.6	2.6
	Pearl River	3	54	3	100.0	1.6	3.6	3.6
New York	Nassau	1	8,919	1	100.0	0.6	0.6	0.6
North Carolina	Buncombe	1	988	1	100.0	0.4	0.4	0.5
	Henderson	1	317	1	100.0	5.9	5.9	5.9
	Macon	1	359	1	100.0	0.2	0.3	0.3
Tennessee	Anderson	1	230	1	100.0	1.1	1.1	1.1
	Shelby	1	3,069	1	100.0	1.6	2.9	2.9
Texas	Cameron	1	410	1	100.0	0.3	0.5	1.6
	Galveston	1	1,056	1	100.0	1.4	1.4	1.5
	Travis	1	4,499	1	100.0	0.8	0.8	0.8
Virginia	Stafford	1	177	1	100.0	1.0	1.5	1.5

Continued on next page...

Access Detail By County

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Grand Totals		**735**	**54,232**	**722**	**98.2**	**1.0**	**1.2**	**1.3**

Access Summary By State Name

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Specialists

Areas Without Access

Bottom 35 State Names in the market, sorted by the number of retirees without access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees Without Access

Retiree Group	**740 retirees** 18 (2.4%) retirees without access	Provider Group	**705,971 unique providers at 91,347 unique locations** (705,971 total access points)

Key Geographic Areas

	State Name	Retiree	Without Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
Without Access	Louisiana	710	13	1.8	16,953	11.9	12.6	12.6
	Mississippi	10	2	20.0	4,244	19.7	20.8	21.0
	California	2	1	50.0	22,213	1.8	10.8	12.0
	Florida	3	1	33.3	19,767	9.6	68.9	68.9
	North Carolina	4	1	25.0	41,955	13.2	13.8	13.8

Access Detail By County

August 17, 2022

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Access Analysis

2 Specialists in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Specialists

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Specialists) providers in 10 miles

Retirees Without Access								
State Name	County	Retiree Counts		Without Access[1]		Average Distance		
		#	#	#	%	1	2	3
California	San Diego	1	3,874	1	100.0	1.8	10.8	12.0
Florida	Miami-Dade	1	0	1	100.0	9.6	68.9	68.9
Louisiana	St. Tammany	71	1,391	13	18.3	11.9	12.6	12.6
Mississippi	Franklin	1	0	1	100.0	26.7	28.9	29.3
	Marion	1	8	1	100.0	12.6	12.6	12.6
North Carolina	Rutherford	1	85	1	100.0	13.2	13.8	13.8
Grand Totals		**76**	**5,358**	**18**	**23.7**	**12.2**	**16.6**	**16.7**

Access Overview

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Hospitals

Access Map

Retiree locations

◆ With access

● Without access

Retiree locations

◆ All Retirees

Service areas:

Medicare Advantage HMO

678.29 miles

Comparison Graph

Percent of retirees with access to a choice of providers over miles

1st closest

2nd closest

3rd closest

4th closest

5th closest

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

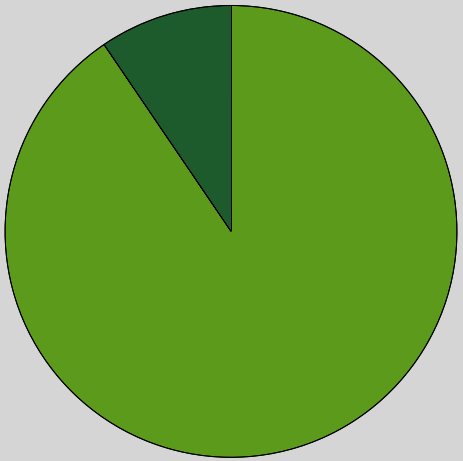
2 (Hospitals) providers in 10 miles

Overall Access[1]

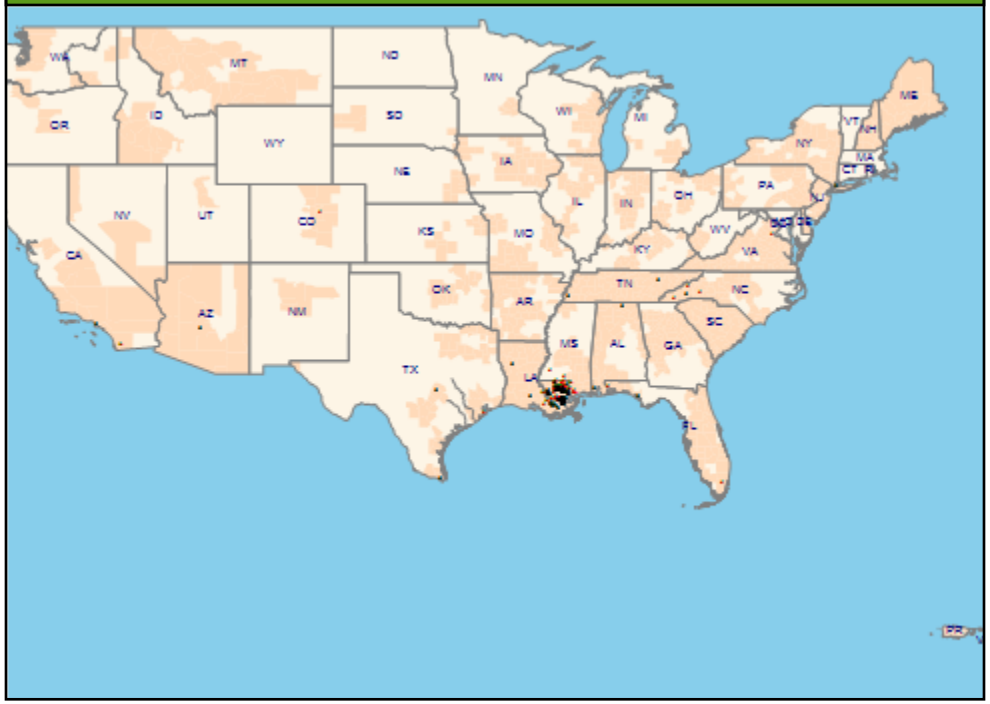
740 Retirees
4,517 providers at 3,245 locations (Jefferson Parish Government)

670 (90.5%) Retirees with access

70 (9.5%) Retirees without access



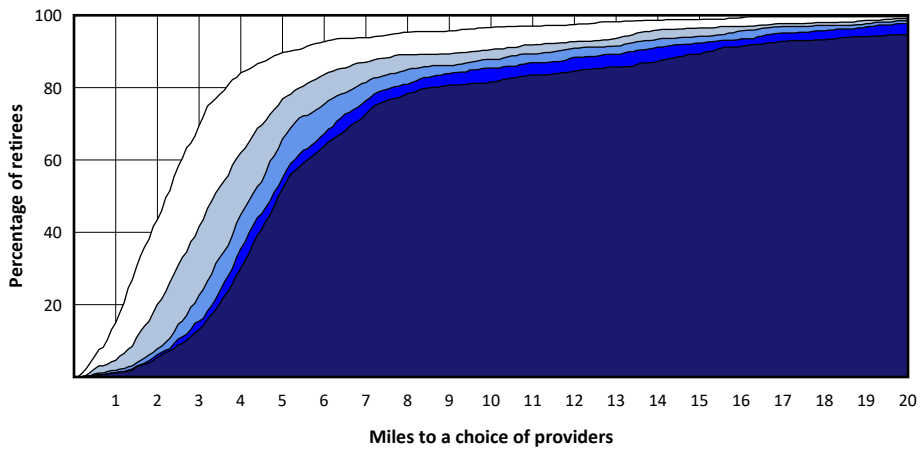
All Employees



Distances

	Average
Distance to 1st closest provider	3.0 miles
Distance to 2nd closest provider	4.6 miles
Distance to 3rd closest provider	5.7 miles
Distance to 4th closest provider	6.4 miles
Distance to 5th closest provider	7.1 miles

Access Standard Comparison



Access Summary By State Name

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Hospitals

Areas With Access

Top 35 State Names in the market, sorted by the number of retirees with access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Hospitals) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees With Access

Retiree Group	**740 retirees** 670 (90.5%) retirees with access	Provider Group	**4,517 unique providers at 3,245 unique locations** (4,517 total access points)

Key Geographic Areas

	State Name	Retiree	With Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
With Access	Louisiana	710	659	92.8	230	2.4	3.4	4.4
	Alabama	2	2	100.0	105	4.4	6.0	8.0
	Tennessee	2	2	100.0	320	5.0	5.7	12.3
	Texas	3	2	66.7	393	2.1	4.4	5.8
	Arizona	1	1	100.0	102	4.4	4.5	6.7
	California	2	1	50.0	180	0.8	2.8	8.1
	Florida	3	1	33.3	253	4.8	4.8	6.9
	New York	1	1	100.0	164	0.6	0.6	3.8
	North Carolina	4	1	25.0	191	7.7	7.7	10.3

Access Detail By County

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree / Provider Groups

Jefferson Parish Government Hospitals

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Hospitals) providers in 10 miles

Retirees With Access								
State Name	County	Retiree Counts		With Access[1]		Average Distance		
		#	#	#	%	1	2	3
Alabama	Madison	1	4	1	100.0	5.6	5.8	6.0
	Mobile	1	11	1	100.0	3.2	6.1	9.9
Arizona	Maricopa	1	63	1	100.0	4.4	4.5	6.7
California	Los Angeles	1	62	1	100.0	0.8	2.8	8.1
Florida	Bay	1	5	1	100.0	4.8	4.8	6.9
Louisiana	Ascension	5	6	5	100.0	4.8	4.8	4.8
	East Baton Rouge	2	25	2	100.0	2.0	3.0	3.4
	Jefferson	538	15	538	100.0	2.2	3.2	4.1
	Lafayette	1	13	1	100.0	1.2	1.2	1.9
	Lafourche	6	6	6	100.0	3.5	3.5	16.1
	Livingston	3	3	1	33.3	2.5	2.5	2.5
	Natchitoches	1	2	1	100.0	0.9	1.0	32.3
	Orleans	24	9	24	100.0	3.1	3.9	4.9
	Plaquemines	3	0	3	100.0	5.2	8.1	9.3
	St. Charles	9	1	4	44.4	6.1	7.3	8.1
	St. Tammany	71	16	53	74.6	3.2	3.7	4.3
	Tangipahoa	23	7	19	82.6	4.0	6.2	8.3
	Terrebonne	1	4	1	100.0	3.2	3.2	3.4
	Washington	7	4	1	14.3	1.3	1.8	1.8
New York	Nassau	1	16	1	100.0	0.6	0.6	3.8
North Carolina	Henderson	1	5	1	100.0	7.7	7.7	10.3
Tennessee	Anderson	1	2	1	100.0	2.1	2.3	12.8
	Shelby	1	21	1	100.0	7.9	9.1	11.8
Texas	Cameron	1	6	1	100.0	2.3	5.8	5.8
	Travis	1	29	1	100.0	1.8	3.0	5.7
Grand Totals		**705**	**335**	**670**	**95.0**	**2.4**	**3.4**	**4.5**

Access Summary By State Name

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree Group

Jefferson Parish Government

Provider Group

Hospitals

Areas Without Access

Bottom 35 State Names in the market, sorted by the number of retirees without access

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Hospitals) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

Retirees Without Access

Retiree Group	**740 retirees** 70 (9.5%) retirees without access	Provider Group	**4,517 unique providers at 3,245 unique locations** (4,517 total access points)

Key Geographic Areas

	State Name	Retiree	Without Access[1]		Counts[2]	Average Distance		
		#	#	%	#	1	2	3
Without Access	Louisiana	710	51	7.2	230	7.2	13.9	14.9
	Mississippi	10	10	100.0	78	7.5	20.8	21.0
	North Carolina	4	3	75.0	191	9.0	16.6	18.2
	Florida	3	2	66.7	253	48.2	51.0	51.9
	California	2	1	50.0	180	24.1	26.6	26.6
	Colorado	1	1	100.0	53	5.9	13.4	15.5
	Texas	3	1	33.3	393	5.2	16.7	30.3
	Virginia	1	1	100.0	154	2.3	13.1	13.2

Access Detail By County

August 17, 2022

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Access Analysis

2 Hospitals in 10 miles

Retiree / Provider Groups

Jefferson Parish Government

Hospitals

[1] The Access Standard is defined as (Jefferson Parish Government) retirees accessing:

2 (Hospitals) providers in 10 miles

Retirees Without Access								
State Name	County	Retiree Counts		Without Access[1]		Average Distance		
		#	#	#	%	1	2	3
California	San Diego	1	12	1	100.0	24.1	26.6	26.6
Colorado	Douglas	1	4	1	100.0	5.9	13.4	15.5
Florida	Escambia	1	10	1	100.0	11.9	11.9	11.9
	Miami-Dade	1	0	1	100.0	84.5	90.0	91.9
Louisiana	Assumption	1	1	1	100.0	1.9	11.3	11.3
	Livingston	3	3	2	66.7	10.3	12.8	14.4
	St. Charles	9	1	5	55.6	2.4	12.0	12.9
	St. Helena	1	1	1	100.0	4.4	11.1	16.7
	St. James	2	1	2	100.0	1.0	11.5	19.1
	St. John the Baptist	10	1	10	100.0	2.8	13.8	15.4
	St. Mary	1	2	1	100.0	1.5	24.7	24.8
	St. Tammany	71	16	18	25.4	12.4	13.4	13.4
	Tangipahoa	23	7	4	17.4	7.0	12.8	14.3
	Washington	7	4	6	85.7	6.3	18.8	19.0
	West Baton Rouge	1	0	1	100.0	7.2	10.8	11.3
Mississippi	Franklin	1	0	1	100.0	33.2	34.3	35.1
	Hancock	5	1	5	100.0	3.7	17.2	17.6
	Marion	1	1	1	100.0	14.2	30.7	30.7
	Pearl River	3	2	3	100.0	3.0	18.8	18.8
North Carolina	Buncombe	1	3	1	100.0	10.1	10.1	11.6
	Macon	1	2	1	100.0	0.8	16.9	19.3
	Rutherford	1	1	1	100.0	16.2	22.8	23.6
Texas	Galveston	1	3	1	100.0	5.2	16.7	30.3
Virginia	Stafford	1	1	1	100.0	2.3	13.1	13.2
Grand Totals		**148**	**77**	**70**	**47.3**	**8.6**	**16.3**	**17.4**

TOP 100 NDCs BY TIER

	RANK	BRAND_NAME	2023 TIER_NBR	2021 SUM_of_RX_Tot
HUMANA	1	ATORVASTATIN CALCIUM	1	832
	2	AMLODIPINE BESYLATE	1	674
	3	LEVOTHYROXINE SODIUM	1	528
	4	METOPROLOL SUCCINATE ER	1	509
	5	LOSARTAN POTASSIUM	1	418
	6	ROSUVASTATIN CALCIUM	1	387
	7	PANTOPRAZOLE SODIUM	1	341
	8	LISINOPRIL	1	326
	9	METFORMIN HYDROCHLORIDE	1	316
	10	GABAPENTIN	1	299
	11	HYDROCHLOROTHIAZIDE	1	289
	12	OMEPRAZOLE	1	280
	13	PRAVASTATIN SODIUM	1	275
	14	FUROSEMIDE	1	274
	15	ELIQUIS	2	263
	16	TAMSULOSIN HYDROCHLORIDE	1	260
	17	ALPRAZOLAM	1	249
	18	CLOPIDOGREL	1	248
	19	ALLOPURINOL	1	210
	20	HYDROCODONE BITARTRATE/ACETAMINOPHEN	1	203
	21	TRAMADOL HCL	1	199
	22	METFORMIN HYDROCHLORIDE ER	1	187
	23	ESCITALOPRAM OXALATE	1	184
	24	FLUTICASONE PROPIONATE	1	178
	25	POTASSIUM CHLORIDE ER	1	177
	26	METOPROLOL TARTRATE	1	175
	27	CARVEDILOL	1	165
	28	OXYCODONE/ACETAMINOPHEN	1	163
	29	MELOXICAM	1	149
	30	SIMVASTATIN	1	144
	31	FINASTERIDE	1	143
	32	PREDNISONE	1	136
	33	LATANOPROST	1	135
	34	IRBESARTAN	1	134
	35	MONTELUKAST SODIUM	1	125
	36	XARELTO	2	123
	37	DULOXETINE HYDROCHLORIDE	1	117
	38	AMOXICILLIN	1	117
	39	ESTRADIOL	1	116
	40	ALBUTEROL SULFATE HFA	1	111
	41	TRAZODONE HYDROCHLORIDE	1	106
	42	SERTRALINE HYDROCHLORIDE	1	105
	43	QUETIAPINE FUMARATE	1	104
	44	EZETIMIBE	1	103
	45	JARDIANCE	2	102
	46	CITALOPRAM HYDROBROMIDE	1	100
	47	ALENDRONATE SODIUM	1	100
	48	PREGABALIN	1	97
	49	LORAZEPAM	1	96
	50	MYRBETRIQ	2	94
	51	GLIMEPIRIDE	1	93
	52	JANUVIA	2	90
	53	AMOXICILLIN/CLAVULANATE POTASSIUM	1	89
	54	SPIRONOLACTONE	1	89
	55	ATENOLOL	1	89

56	DOXYCYCLINE HYCLATE	1	87
57	CLONAZEPAM	1	85
58	CIPROFLOXACIN HYDROCHLORIDE	1	84
59	HYDROCODONE/ACETAMINOPHEN	1	84
60	MEMANTINE HYDROCHLORIDE	1	84
61	FAMOTIDINE	1	83
62	BUPROPION HYDROCHLORIDE ER (XL)	1	82
63	TEMAZEPAM	1	81
64	TRULICITY	2	79
65	SERTRALINE HCL	1	76
66	CYCLOBENZAPRINE HYDROCHLORIDE	1	75
67	CLONIDINE HYDROCHLORIDE	1	74
68	FLUOXETINE HCL	1	72
69	LISINOPRIL/HYDROCHLOROTHIAZIDE	1	72
70	FENOFIBRATE	1	71
71	AZITHROMYCIN	1	71
72	DONEPEZIL HCL	1	70
73	DICLOFENAC SODIUM	1	70
74	OLMESARTAN MEDOXOMIL	1	69
75	LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE	1	68
76	HYDRALAZINE HYDROCHLORIDE	1	67
77	SYNTHROID	2	67
78	OXYBUTYNIN CHLORIDE ER	1	67
79	OZEMPIC	2	67
80	ZOLPIDEM TARTRATE	1	67
81	ENTRESTO	2	66
82	CEPHALEXIN	1	66
83	SHINGRIX	1	65
84	WARFARIN SODIUM	1	65
85	TIZANIDINE HYDROCHLORIDE	1	65
86	LOVASTATIN	1	64
87	METHYLPREDNISOLONE DOSE PACK	1	64
88	ISOSORBIDE MONONITRATE ER	1	62
89	AZELASTINE HYDROCHLORIDE	1	61
90	TRIAMCINOLONE ACETONIDE	1	61
91	LEVOCETIRIZINE DIHYDROCHLORIDE	1	59
92	ESOMEPRAZOLE MAGNESIUM	1	59
93	SULFAMETHOXAZOLE/TRIMETHOPRIM DS	1	58
94	MIRTAZAPINE	1	57
95	NITROGLYCERIN	1	57
96	FLUOXETINE HYDROCHLORIDE	1	57
97	BD SWABS SINGLE USE	1	56
98	TRIAMTERENE/HYDROCHLOROTHIAZIDE	1	55
99	COMBIGAN	2	55
100	CHLORTHALIDONE	1	54
101	BUMETANIDE	1	54
102	LEVEMIR FLEXTOUCH	2	54

Attachment A
Licensing Credentials

State of Louisiana

James J. Donelon

COMMISSIONER OF INSURANCE

CERTIFICATE OF AUTHORITY

Whereas, the HUMANA INSURANCE COMPANY located at Wisconsin has applied for a certificate of authority and made the filings required of such Insurer. Therefore, I, James J Donelon, the undersigned Commissioner of Insurance, do hereby certify that the said HUMANA INSURANCE COMPANY is authorized to transact its appropriate business of Health and accident; Life Insurance in this State, in accordance with the laws thereof. This certificate shall remain in effect until cancelled, suspended, revoked or the renewal thereof refused.

In Testimony Whereof, I hereunto subscribe my name, and affix the seal of my office at Baton Rouge this 1st day of January A.D 2010.

James J. Donelon
Commissioner of Insurance

Amended: Original certificate effective date November 13, 1984

LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

December 22, 2009

HUMANA INSURANCE COMPANY
321 West Main Street
7th FloorLouisvilleKY40202

RE: Issuance of Revised Certificate of Authority Pursuant to Act 326 of the 2009 Regular Legislative Session

To Whom it May Concern:

As you may be aware, Act 326 of the 2009 Regular Legislative Session made certain changes to the types of insurance and the definitions thereof that may be offered in Louisiana. The enclosed amended Certificate of Authority has been issued to be effective January 1, 2010 in compliance with those changes.

The amended Certificate should reflect all lines of authority which the above addressed company is legally authorized to write in Louisiana. The changes should not result in the loss of authority to write a line of insurance which a company was previously authorized to write in this state.

You may view a copy of Act 326 including the types of insurance and the definitions thereof at http://www.legis.state.la.us/billdata/streamdocument.asp?did=667831.

Should you have any questions, problems or concerns about the Act or the amended Certificate of Authority, please contact the Company Licensing Division of the Louisiana Department of Insurance at 225-219-4318 or via email to mboutwell@ldi.state.la.us or csarvis@ldi.state.la.us.

Sincerely,

M E. Boutwell

Mike Boutwell
Director of Company Licensing
Louisiana Department of Insurance

P. O. BOX 94214 • BATON ROUGE, LOUISIANA 70804-9214
PHONE (225) 342-5900 • FAX (225) 342-3078
http://www.ldi.state.la.us

State of Louisiana

J. ROBERT WOOLEY

COMMISSIONER OF INSURANCE

I, THE UNDERSIGNED **COMMISSIONER OF INSURANCE** OF THE STATE OF LOUISIANA,

DO HEREBY CERTIFY THAT

HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.

has complied with all requirements and is hereby licensed to act as a
HEALTH MAINTENANCE ORGANIZATION
in the State of Louisiana
This license shall remain in effect until canceled, suspended, revoked or the renewal thereof refused.

Given Under my signature, authenticated with the impress of my Seal of office, at the City of Baton Rouge, this, 1st day of May A.D. 2004

J. Robert Wooley
Commissioner of Insurance

Attachment B
Sample of Jefferson Parish's MAPD Enrollment Materials

Humana.

A more human way
to healthcare™

Y0040_GHHL9PNEN_22_C

BC22

Humana Group Medicare
Humana Inc.
P.O. Box 669
Louisville, KY 40201-0669

Important plan information

Beyond healthcare

At Humana, we give you everything you expect from a healthcare plan, but that's just our starting point. We then find more ways to help, and more ways to support your health and your goals. That's human care, and it's just the way things ought to be.

Jefferson Parish Government

What's inside

- Welcome Letter
- Medical Summary of Benefits
- Rx Summary of Benefits
- Guidebook
- Go365® Flyer
- Prescription Drug Guide
- Enrollment Form Checklist
- Enrollment Form
- Business Reply Envelope

What to expect after you enroll

Enrollment confirmation

You'll receive a letter from Humana once the Centers for Medicare & Medicaid Services (CMS) confirms your enrollment.

Humana member ID card

Your Humana member ID card will arrive in the mail shortly after you enroll.

Evidence of Coverage (EOC)

This detailed booklet about your healthcare coverage with your plan will arrive in the mail. This will also include your privacy notice.

Take your Medicare Health Assessment

CMS requires Humana to ask new members to complete a health survey within their first few months of enrollment.

It's nine simple questions about your health. Your answers will help us guide you to tools and resources available to help you reach your health goals. The information you provide will not affect your plan premiums or benefits.

Once you have received your Humana member ID card or after your plan is effective, you can call our automated voice service anytime to take this survey at **1-888-445-3389 (TTY: 711)**. When you call, you'll be asked to provide your eight-digit member ID number located on the front of your Humana member ID card, so have your ID card handy.

We're here for you!

Humana Group Medicare Customer Care
1-866-396-8810 (TTY: 711)
Monday – Friday, 8 a.m. – 9 p.m., Eastern time

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Call **1-866-396-8810 (TTY: 711)** for more information.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your Evidence of Coverage for additional details on what your plan may cover or other rules that may apply.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Welcome to Humana Group Medicare Advantage HMO Plan

Take action to enroll

Dear Group Medicare Beneficiary,

We're excited to let you know that **Jefferson Parish Government** has asked Humana to offer you a Medicare Advantage and Prescription Drug HMO plan that gives you more benefits than Original Medicare.

At Humana, helping you achieve lifelong well-being is our mission. During our over 30 years of experience with Medicare, we've learned how to be a better partner in health.

Get to know your plan

Review the enclosed materials. This packet includes information on your Group Medicare healthcare option along with extra services Humana provides.

- If you have questions about your premium, please call your benefits administrator at 1-504-364-2668 (TTY :711).

Next Steps

- To begin your Humana coverage, please enroll before your effective date by filling out the enrollment form in the back of this book and mailing it in the enclosed envelope or fax to **1-877-889-9936**.
- You must complete a separate application for each family member eligible for your plan.
- Please keep a copy of your application for your records.
- Please also fax a copy of your application to Jefferson Parish Government at 1-504-364-3828.

We look forward to serving you now and for many years to come.

Sincerely,
Group Medicare Operations

We're here for you

Humana Group Medicare Customer Care
1-866-396-8810 (TTY: 711), Monday – Friday, 8 a.m. – 9 p.m., Eastern time
Humana.com

2022

Summary of Benefits

Humana Group Medicare Advantage HMO Plan
HMO 076/256

Jefferson Parish Government

Humana®

Our service area includes all parishes in Louisiana.

Let's talk about the **Humana Group Medicare Advantage HMO** Plan.

Find out more about the Humana Group Medicare Advantage HMO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

To be eligible

To join the Humana Group Medicare Advantage HMO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage HMO plan

How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

Or visit our website: **Humana.com**

Humana Group Medicare Advantage HMO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

	IN-NETWORK
PLAN COSTS	
Monthly premium You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact Humana, your employer/union group, or your employer group benefits plan administrator.
Medical deductible	This plan does not have a deductible.
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$2,500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional) and the Plan Premium. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Covered Medical and Hospital Benefits

	IN-NETWORK
ACUTE INPATIENT HOSPITAL CARE	
Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**$150** copay per day for days 1-5
OUTPATIENT HOSPITAL COVERAGE	
Outpatient hospital visits	**$0** to **$100** copay or **20%** of the cost
Ambulatory surgical center	**$75** copay
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$5** copay
Specialists	**$20** copay
PREVENTIVE CARE	
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost**

Note: *some services require prior authorization and referrals from providers.*

Covered Medical and Hospital Benefits

	IN-NETWORK
EMERGENCY CARE	
Emergency room If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	**$65** copay for Medicare-covered emergency room visit(s)
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$5** to **$20** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Diagnostic radiology	**$0** to **$50** copay
Lab services	**$0** copay
Diagnostic tests and procedures	**$0** to **$20** copay
Outpatient X-rays	**$0** to **$20** copay
Radiation therapy	**$0** to **$20** copay
HEARING SERVICES	
Medicare-covered hearing	**$20** copay
Routine hearing TruHearing Provider must be used. Contact Customer Service to locate a provider.	**$0** copay for routine hearing exams up to 1 per year. **$0** copay for follow-up provider visits up to unlimited per year. **$699** copay for each Advanced level hearing aid up to 1 per ear per year. **$999** copay for each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase.
DENTAL SERVICES	
Medicare-covered dental	**$20** copay
Routine dental	**0%** of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years.

Note: *some services require prior authorization and referrals from providers.*

	IN-NETWORK
	0% of the cost for bitewing x-rays up to 1 set(s) per year. **0%** of the cost for periodic oral exam, prophylaxis (cleaning) up to 2 per year. **0%** of the cost for necessary anesthesia with covered service up to unlimited per year. **50%** of the cost for amalgam and/or composite filling up to 2 per year. **$1000** maximum benefit coverage amount per year for preventive and comprehensive benefits.
VISION SERVICES	
Medicare-covered vision services	**$20** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered glaucoma screening	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay
Routine vision EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	**$15** copay for routine exam (includes refraction) up to 1 per year. **$200** maximum benefit coverage amount for eyeglasses-frames up to 1 per year. **$120** maximum benefit coverage amount for premium progressive lenses up to 1 per year. **$0** copay for eyeglasses- lenses up to 1 per year. **$0** copay for contact lenses up to 1 per year.
MENTAL HEALTH SERVICES	
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility	**$150** copay per day for days 1-5
Outpatient group and individual therapy visits	**$5** to **$40** copay

Note: *some services require prior authorization and referrals from providers.*

Covered Medical and Hospital Benefits

	IN-NETWORK
SKILLED NURSING FACILITY	
Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days	**$0** copay per day for days 1-20 **$25** copay per day for days 21-100
PHYSICAL THERAPY	
	$20 to **$40** copay
AMBULANCE	
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$50** copay
PART B PRESCRIPTION DRUGS	
	20% of the cost
ACUPUNCTURE SERVICES	
Medicare-covered acupuncture **20** visit limit per plan year Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**$20** copay
ALLERGY	
Allergy shots & serum	**$0** copay
CHIROPRACTIC SERVICES	
Medicare-covered chiropractic visit(s)	**$20** copay
COVID-19	
Testing and Treatment	**$0** copay for testing and treatment services for COVID-19
DIABETES MANAGEMENT TRAINING	
	$0 copay

Note: *some services require prior authorization and referrals from providers.*

Covered Medical and Hospital Benefits

	IN-NETWORK
FOOT CARE (PODIATRY)	
Medicare-covered foot care	**$20** copay
HOME HEALTH CARE	
	$0 copay
MEDICAL EQUIPMENT/SUPPLIES	
Durable medical equipment (like wheelchairs or oxygen)	**10%** of the cost
Medical supplies	**10%** of the cost
Prosthetics (artificial limbs or braces)	**10%** of the cost
Diabetes monitoring supplies	**0%** of the cost
OUTPATIENT SUBSTANCE ABUSE	
Outpatient group and individual substance abuse treatment visits	**$5** to **$40** copay
OVER-THE-COUNTER ITEMS	
	$50 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.
REHABILITATION SERVICES	
Occupational and speech therapy	**$20** to **$40** copay
Cardiac rehabilitation	**$20** to **$40** copay
Pulmonary rehabilitation	**$20** to **$30** copay
RENAL DIALYSIS	
Renal dialysis	**$0** copay or **20%** of the cost
Kidney disease education services	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care provider (PCP)	**$0** copay
Specialist	**$20** copay
Urgent care services	**$0** copay
Substance abuse or behavioral health services	**$0** copay

Note: *some services require prior authorization and referrals from providers.*

	IN-NETWORK
FITNESS AND WELLNESS	
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.
HOSPICE You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.	

Note: *some services require prior authorization and referrals from providers.*

Notes

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-866-396-8810 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Find out **more**

You can see your plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare our plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Humana®

Humana.com

SB076256EN22

2022

Prescription Drug Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 1

Humana®

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Let's talk about the **Humana Group Medicare Advantage Rx** Plan.

Find out more about the Humana Group Medicare Advantage Rx plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

Deductible

Pharmacy (Part D) deductible This plan does not have a deductible.

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$10** copay	**$10** copay
2 (Preferred Brand)	**$20** copay	**$20** copay
3 (Non-Preferred Drug)	**$40** copay	**$40** copay
4 (Specialty Tier)	**25%** of the cost	**25%** of the cost
90-day supply		
1 (Generic or Preferred Generic)	**$30** copay	**$0** copay
2 (Preferred Brand)	**$60** copay	**$40** copay
3 (Non-Preferred Drug)	**$120** copay	**$80** copay
4 (Specialty Tier)	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary.

ADDITIONAL DRUG COVERAGE

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,430**.
You will continue to pay the same amount as when you were in the initial coverage stage.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the greater of:

- **$3.95** for generic (including brand drugs treated as generic) and a **$9.85** copay for all other drugs, or
- **5%** coinsurance

Notes

Notes

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-866-396-8810 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ niká'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Find out **more**

You can see your plan's pharmacy directory at **https://www.humana.com/finder/pharmacy/** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see your plan's drug formulary at **www.humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage HMO, PPO organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

Humana®

Humana.com

MAPD | HMO GUIDEBOOK

Group Medicare Advantage Guidebook

Health maintenance organization (HMO) plan

At Humana, we know that people are different, and need our support in different ways. Your Group Medicare Advantage HMO plan will center around you, your health and your goals.

This guidebook doesn't list every service, limitation and exclusion in the plan. After you enroll, we'll mail you an Evidence of Coverage booklet that will have all the plan information and details, including a full list of benefits.

Humana®

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Discover a more human way to healthcare

Coverage that fits the way you live

When you become a member of the Humana family, you can expect healthcare designed with you in mind—that meets you where you are today and delivers care that takes you to where you want to be.

Care delivered how and where you need it

We can help you manage complex or chronic health conditions. A Humana nurse can meet you at home, in the hospital, by phone or email to provide valuable support and help you reduce complications.

Benefits that put you first

Our health and well-being tools and resources make it easy to set health goals, chart your progress, strengthen your mind and body and build connections with others. It's about giving you the things you expect from an insurance company—and then finding more ways to help make your life better.

Humana offers you a Medicare Advantage HMO with prescription drug plan

A HMO offers

- All the benefits of Original Medicare, plus extra benefits.
- Maximum out-of-pocket protections.
- Worldwide emergency coverage.
- Programs to help improve health and well-being.
- **A large network.** There are more than 66,000 participating pharmacies in our network.
- **Maximize Your Benefit® Rx.** We want to make sure medication costs aren't keeping you from the care you need.
- **Almost no claims paperwork.** The plan works with your pharmacist to handle claims for you.
- **Pharmacy finder.** An online tool that helps you find pharmacies.

Dedicated team and more

- Your choice of an in-network provider to manage your care
- Large network of providers, specialists and hospitals to pick from
- Coverage for office visits, including routine physical exams
- Coverage for medically necessary stays in the hospital
- Almost no claim forms to fill out or mail—we take care of that for you
- Predictable costs, so you'll know how much your copayments and coinsurance percentages are
- Dedicated Customer Care specialists who serve only our Group Medicare members

What is Medicare?

Medicare is a federal health insurance program for U.S. citizens and legal residents who are 65 and older or qualify due to a disability. You must be entitled to Medicare Part A and enrolled in Medicare Part B as the Humana Group Medicare HMO plan is a Medicare Advantage plan. You must also continue paying Medicare Part B premiums to remain enrolled in this plan.

A

Medicare Part A

HOSPITAL INSURANCE

It helps cover medically necessary inpatient care in a hospital or skilled nursing facility. It also helps cover some home healthcare and hospice care.

B

Medicare Part B

MEDICAL INSURANCE

It helps cover medically necessary providers' services, outpatient care and other medical services and supplies. Part B also helps cover some preventive services.

C

Medicare Part C

MEDICARE ADVANTAGE PLANS

These are available through private insurance companies, such as Humana. Medicare Part C helps cover everything medically necessary that Part A and Part B cover, including hospital and medical services. You still have Medicare if you elect Medicare Part C coverage. You must be entitled to Medicare Part A and enrolled in Part B to be eligible for a Medicare Part C plan.

D

Medicare Part D

PRESCRIPTION DRUG COVERAGE

It helps pay for the medications your provider prescribes and is available in a stand-alone prescription drug plan. Like Part C Medicare Advantage plans, Part D is only available through private companies, such as Humana. Many Part C Medicare Advantage plans include Medicare Part D prescription drug coverage.

Build healthy provider relationships

Your relationship with your provider is important in helping you protect and manage your health.

With the Humana Group Medicare HMO plan, you'll have a primary care provider who will help you manage your care, who knows your medical history and the medications you take. You can pick any provider from our network who is taking new patients, or you can change to another network provider if you choose. If you need to see a specialist, your provider will help you find one.

When you need hospital or outpatient care, you may need a referral. Ask your provider to contact us whenever you're admitted to the hospital. We may have advice and special programs your provider can use to help you heal faster.

Is your healthcare provider in Humana's provider network?

Humana respects your relationship with your provider. We want you to be able to select a provider who's close to home and who can focus on your specific needs. If you need help finding a provider, call our Group Medicare Customer Care team or use our online directory. Humana's online provider lookup is an easy way to find doctors, hospitals and other healthcare providers in Humana's network:

- Go to **Humana.com** and select "Find a doctor"
- Get provider phone numbers, addresses and directions
- Customize your search by specialty, location and name

Is your pharmacy in Humana's network?

Your relationship with your pharmacist is important in protecting and managing your health. You must use network pharmacies to enjoy the benefits of our plan except in an emergency. Pharmacies in the network have agreed to work with Humana to fill prescriptions for our members. If you use a pharmacy outside the network, your costs may be higher.

Our pharmacy network includes access to mail delivery, specialty, retail, long-term care, home infusion, and Indian, tribal and urban pharmacies.

You can find a complete list of network pharmacies at MyHumana, your personal, secure online account at **Humana.com**, and the MyHumana Mobile app.* Get printable maps and directions, along with many more details to find a pharmacy that fits your needs. Other information at **Humana.com/pharmacy/medicare/tools** includes:

- Printable Drug Lists
- Prior authorization information
- Maximize Your Benefit Rx

Medical preauthorization

For certain services and procedures, your provider or hospital may need to get advance approval from Humana before your plan will cover any costs. This is called prior authorization or preauthorization. Providers or hospitals will submit the preauthorization request to Humana. If your provider hasn't done this, please call our Customer Care team, as Humana may not be able to pay for these services.

*Standard data rates may apply.

Connect with a provider virtually

Care when you need it

Your primary care provider may offer virtual visits as another convenient way to be treated by your care team.

What are virtual visits?

Virtual visits connect you with your provider via telephone or video chat using your phone, tablet or computer.* They may allow you to get help with chronic condition management, follow-up care after an in-office visit, medication reviews and refills and much more, just like an in-office visit.

When should I use it?

- For a nonemergency issue, instead of going to the emergency room (ER) or an urgent care center.
- For nonemergency mental and behavioral health conditions a behavioral health specialist may offer virtual visits.

What kinds of conditions can be treated?

Providers may help with chronic condition management, follow-up care after an in-office visit, medication reviews and refills in addition to many other conditions including but not limited to: allergies, fever, cold and flu symptoms, sore throat, constipation, sinus infection, diarrhea, insect bites and depression, anxiety, stress and family and relationship counseling.

Call your provider to find out if they offer virtual visits and if so, what you need to do to get started.

If you don't have a primary care provider or if your PCP doesn't offer virtual visits, you can use the "Find a doctor" tool on **Humana.com** or call the number on the back of your member ID card to get connected with a provider that offers this service.

Remember, when you have a life-threatening injury or major trauma, call 911.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your Evidence of Coverage for additional details on what your plan may cover or other rules that may apply.

*Standard data rates may apply.

Vaccines: Where you get them determines how much you pay

The Medicare Part D portion of your plan covers all commercially available vaccines—except for those covered by Part B—as long as the vaccine is reasonable and necessary to help prevent illness.

Get vaccines like the ones listed below at your provider's office

The Medicare Part B portion of your plan pays for the following vaccines at your provider's office and at the pharmacy: influenza (flu) vaccine—once per season; pneumococcal vaccines; hepatitis B vaccines for persons at increased risk of hepatitis and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus.

Get vaccines like the ones listed below at a network pharmacy

If you get them at your provider's office, you'll pay the full cost of the vaccine out of pocket. Some common vaccines that you should get at your pharmacy, not from your provider, are shingles, Tdap and hepatitis A.

Understanding your diabetes coverage

At Humana, we make it easy for you to understand your benefits and get what you need to help manage your condition.

Diabetes prescriptions and supplies, Part B vs. Part D

Medicare Part B
- Diabetic testing supplies
- Insulin pumps*
- Continuous glucose monitors (CGM)*
- Insulin administered (or used) in insulin pumps

Medicare Part D
- Diabetes medications
- Insulin administered (or used) with syringes or pens
- Syringes, pen needles or other insulin administration devices that are not durable medical equipment (e.g., Omnipod* or VGO)

Diabetic testing supplies

Your Humana Medicare Advantage Plan helps cover a variety of diabetic glucose testing supplies. Humana Pharmacy® is the preferred supplier for the meters listed below and their test strips and lancets:

Roche Accu-Chek Guide Me®, Roche Accu-Chek Guide and HP® True Metrix® AIR by Trividia. To order a meter and supplies from Humana Pharmacy, call **1-888-538-3518 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

Your doctor can also send prescriptions for meters and other testing supplies by fax or e-prescribe.

You can also request a no-cost meter from the manufacturer by calling Roche at **1-877-264-7263 (TTY: 711)**, or Trividia Health at **1-866-788-9618 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Go to **Humana.com/Diabetes** to learn more about managing your diabetes. MyDiabetesPath® offers a complete guide to living with diabetes and gives you the information and resources to help you maintain your health.

*Available through our preferred durable medical equipment (DME) vendors, CCS Medical **1-877-531-7959** or Edwards Healthcare **1-888-344-3434**.

You have the choice of pharmacies—Humana Pharmacy is one option

More and more Humana members are finding Humana Pharmacy to be their choice for value, experience, safety, accuracy, convenience and service.

Why choose Humana Pharmacy?

- **Savings**. The pharmacy team works with you and your provider to find medications that cost less.
- **Experienced pharmacy team**. Pharmacists are available to answer questions about your medication(s) and our services.
- **Safe and accurate**. Two pharmacists check your new prescriptions to make sure they're safe to take with your other medication(s). The dispensing equipment and heat–sealed bottles with tamper-resistant foil help ensure quality and safety. Plus, your order comes in plain packaging for additional security.
- **Timely reminders**. To help make sure you have the medication(s) and supplies you need when you need them, we can remind you when it's time to refill your medications. Just set your preferences when you sign up at **HumanaPharmacy.com**.
- **Time-saving mail delivery**. Your medication(s) will be shipped safely and securely to the location of your choice. That means no more trips to the pharmacy. No more waiting in lines to pick up your medication(s). No more hassle. You may be able to order just four times a year and have more time to do the things you enjoy.

Make Humana Pharmacy your one source

Maintenance medication(s). Medication(s) you take all the time for conditions like high cholesterol, high blood pressure and asthma.

Specialty medication(s). Specialized therapies to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

Visit HumanaPharmacy.com

After you become a Humana member, you can sign in with your MyHumana identification number or register to get started. You can also sign up by calling **1-800-379-0092 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

Online

HumanaPharmacy.com. Start a new prescription, order refills, check on your order and get information about how to get started.

Provider

Let your provider know he or she can send prescriptions electronically through e-prescribe. Providers can also fill out the fax form by downloading it from **HumanaPharmacy.com/forms** and faxing the prescription to Humana Pharmacy at **1-800-379-7617** or Humana Specialty Pharmacy® at **1-877-405-7940**.

Mail

Download the "Registration & Prescription Order Form" from **HumanaPharmacy.com/forms** and mail your paper prescriptions to:

Humana Pharmacy
P.O. Box 745099
Cincinnati, OH 45274-5099

Phone

For maintenance medication(s), call Humana Pharmacy at **1-800-379-0092 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

For specialty medication(s), call Humana Specialty Pharmacy® at **1-800-486-2668 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

Humana Pharmacy Mobile app

HumanaPharmacy.com/about/mobile-apps.cmd
Download our Humana Pharmacy app from the iTunes App Store or on Google Play. Sign in or select "Transfer Rx as guest" from the home screen.

*Some prescriptions are only available in a 30-day supply.

Prescription drug tiers

Tier 1 – Generic or preferred generic

Essentially the same drugs, usually priced differently
Have the same active ingredients as brand-name drugs and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as brand-name drugs. Your cost for generic drugs is usually lower than your cost for brand-name drugs.

Tier 2 – Preferred brand

A medication available to you for less than a nonpreferred
Generic or brand-name drugs that Humana offers at a lower cost to you than nonpreferred drugs.

Tier 3 – Nonpreferred drug

A more expensive drug than a preferred
More expensive generic or brand-name prescription drugs that Humana offers at a higher cost to you than preferred drugs.

Tier 4 – Specialty

Drugs for specific uses
Some injectable and other high-cost drugs to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

Medication therapy management

As part of your Medicare Part D coverage with Humana, you might be able to take part in a program called Medication Therapy Management (MTM) at no extra cost. MTM may help you to:

- Know more about getting the greatest benefit from your medications
- Reduce risk by learning how to avoid harmful side effects
- Possibly save money by finding lower-cost alternatives to prescribed medications

Who's eligible?

Members are chosen for MTM using the following Centers for Medicare & Medicaid Services (CMS) and Humana criteria:

- Have three of the five multiple chronic conditions:
  - Mental health-Bipolar
  - Hypertension
  - Dyslipidemia (high or low LDL cholesterol)
  - Osteoporosis
  - Chronic obstructive pulmonary disease (COPD)
- Take at least eight chronic/maintenance Part D drugs
- Spend more than $4,696 on prescription drugs per calendar year

How does the program work?

MTM offers additional information in the SmartSummary that can help to manage medications and drug costs. Members also get a face-to-face or phone consultation with a healthcare professional to talk about their medications.

Scheduling a consultation

If you qualify for MTM, you will receive an invitation letter and see a note in your SmartSummary to call the MTM call center. If you think you qualify but don't see the note, please call the Group Medicare Customer Care phone number. Although the MTM program is a special service offered at no cost to Medicare members, it is not considered a benefit.

It's about giving you more: more time getting to know you, more services—some that you expect and many that you don't—and more ways to help you live the way you want.

Important information about your prescription drug coverage

Some drugs covered by Humana may have requirements or limits on coverage. These requirements and limits may include prior authorization, step therapy or quantity limits. You can visit **Humana.com** to register or sign in and select Pharmacy or call Humana's Group Medicare Customer Care team to check coverage on the medications you take.

Prior authorization

The Humana Group Medicare Plan requires you or your provider to get prior authorization for certain drugs. This means that you will need to get approval from the Humana Group Medicare Plan before you fill your prescriptions. The reason a prior authorization is required can vary depending on the medication. Humana will work with your provider when a prior authorization is required.

If your provider prescribes a drug that needs prior authorization, please be sure the prior authorization has been submitted to Humana before the prescription is filled. The Centers for Medicare & Medicaid Services (CMS) requires a turnaround time of 72 hours for a prior authorization. However, an expedited review can be requested by your provider if waiting 72 hours may be harmful to you.

Step therapy

In some cases, the Humana Group Medicare Plan requires that you first try certain drugs to treat your medical condition before coverage is available for a more expensive drug prescribed to treat your medical condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Group Medicare Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Group Medicare Plan can then cover Drug B.

A step therapy prescription can be filled once the necessary requirements are met. If you have already tried other medications that did not provide the desired clinical results, or you had an adverse reaction, your provider may submit this information to Humana for consideration in meeting the step therapy requirements.

Quantity limits

For some drugs, the Humana Group Medicare Plan limits the quantity of the drug that is covered. The Humana Group Medicare Plan might limit how many refills you can get or quantity of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of tier placement.

One-time transition fill

For certain drugs typically requiring prior authorization or step therapy, Humana will cover a one-time, 30-day supply of your Part D covered drug during the first 90 days of your enrollment. Once you have received the transition fill* for your prescription requiring a prior authorization or step therapy, you'll receive a letter from Humana telling you about the requirements or limits on the prescription. The letter will also advise that you will need to get approval before future refills will be covered. A prior authorization will need to be approved or other alternative medications should be tried if the medication requires step therapy.

Next steps for you

1. Visit **Humana.com/Pharmacy** or call the Customer Care number on the back of your Humana member ID card to see if your medications have quantity limits, or require a prior authorization or step therapy.
2. Talk to your provider about your drugs if they require prior authorization, step therapy is needed or has quantity limits.
3. If you have questions about your prescription drug benefits, please call our Customer Care number on the back of your Humana member ID card.

What should your provider do to meet quantity limits, prior authorization or step therapy drug requirements?

- Go online to **Humana.com/Provider** and visit our provider prior authorization page. This page has a printable form that can be mailed or faxed to Humana.
- Call **1-800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team. They are available Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

Remember: Before making a change, you should always talk about treatment options with your provider.

*Some drugs do not qualify for a transitional fill, such as drugs that require a Part B vs D determination, CMS Excluded drugs, or those that require a diagnosis review to determine coverage.

Extras that may help you improve your overall well-being, at no additional cost

SilverSneakers

SilverSneakers® gives you access to exercise equipment, group fitness classes and social events.

- Use thousands of fitness locations nationwide, with weights, swimming, classes and cardio equipment*,†
- Make friends and enjoy social activities
- Work toward improving muscle strength, bone density, flexibility and balance
- Enjoy group fitness classes outside traditional gyms†
- Start workout programs tailored to your level with the SilverSneakers GO™ app
- Try SilverSneakers On-Demand™ online workout videos that feature tips on fitness and nutrition

Visit **SilverSneakers.com/StartHere** to get your SilverSneakers ID number and find a convenient location near you, or call **1-888-423-4632 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

*Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

†Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

Humana Care Management

Humana care management programs support qualifying members to help them remain independent at home, by providing education about chronic conditions and medication adherence, help with discharge instructions, accessing community resources, finding social support and more, all included in the plan at no additional cost.

For more information, call **1-800-432-4803 (TTY: 711),** Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time.

Humana Well Dine® meal program

After your overnight inpatient stay in a hospital or nursing facility, you're eligible to receive up to 28 nutritious meals (2 meals per day for 14 days). The meals will be delivered to your door at no additional cost to you.

For more information, please contact the number on the back of your Humana member ID card.

Your health at your fingertips with MyHumana

Get your personalized health information on MyHumana

As a Humana member, you can set up a secure, online account called MyHumana and always know where to find your plan information. It's convenient and personalized for you. Whether you prefer using a desktop, laptop or smartphone, you can access your information anytime.*

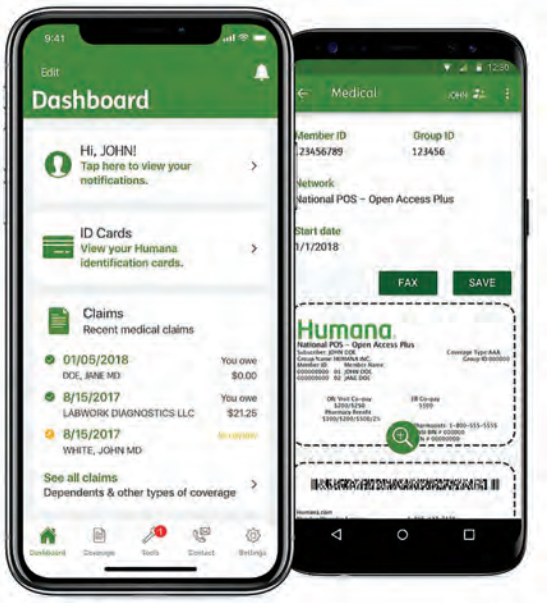
Getting started is easy—just have your Humana member ID card ready and follow these three steps.

1. **Create your account.**
   Visit **Humana.com/registration** and select the "Start activation now" button.

2. **Choose your preferences.**
   The first time you sign into your MyHumana account, be sure to choose how you want to receive information from us—online or mailed to your home. You can update your communication preferences at any time.

3. **View your plan benefits.**
   After you set up your account, be sure to view your plan documents so you understand your benefits and costs. You can also update your member profile if your contact information has changed.

*Standard data rates may apply.



The MyHumana Mobile app

If you have an iPhone or Android, download the MyHumana Mobile app. You'll have your plan details with you at all times.*

Visit **Humana.com/mobile-apps** to learn about our many mobile apps, the app features and how to use them.

With MyHumana and the MyHumana Mobile app, you can:

- Review your plan benefits and claims
- Find pharmacies in your network
- Find providers in your network
- Compare drug prices
- Access digital ID cards
- Establish communication preferences

Have questions?

If you need help along the way, select the green "Chat with Us" button or call Customer Care at the number on the back of your Humana member ID card.

Making sure your helpers can help you—so you can focus on living your life

Choose a caregiver to help you

Everyone needs a little help now and then. We're happy to work with you and whomever you designate as a helper. Many people trust a family member or close friend to help them with their healthcare—someone who may help you talk with us about your insurance plan, keep track of your benefits and claims, or ask healthcare questions on your behalf.

Visit **Humana.com/caregiver** to learn more about naming a caregiver and how to submit the Consent for Release of Protected Health Information (PHI) form.

Consent forms

We need your permission to share your personal information with someone else. To give your permission, you'll need to read and sign a consent form.

Consent return

- After you complete and sign the form, fax it to **1-800-633-8188**.
- If you prefer to mail your completed form, mail to:
  Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168

A signed consent form allows insurers to share health plan information and protected health information with your designated helper. It's different from granting medical power of attorney, which allows someone to make decisions about your care.

Your personalized benefits statement

We make it easy for you to understand, track, manage and possibly save money on your healthcare with SmartSummary®

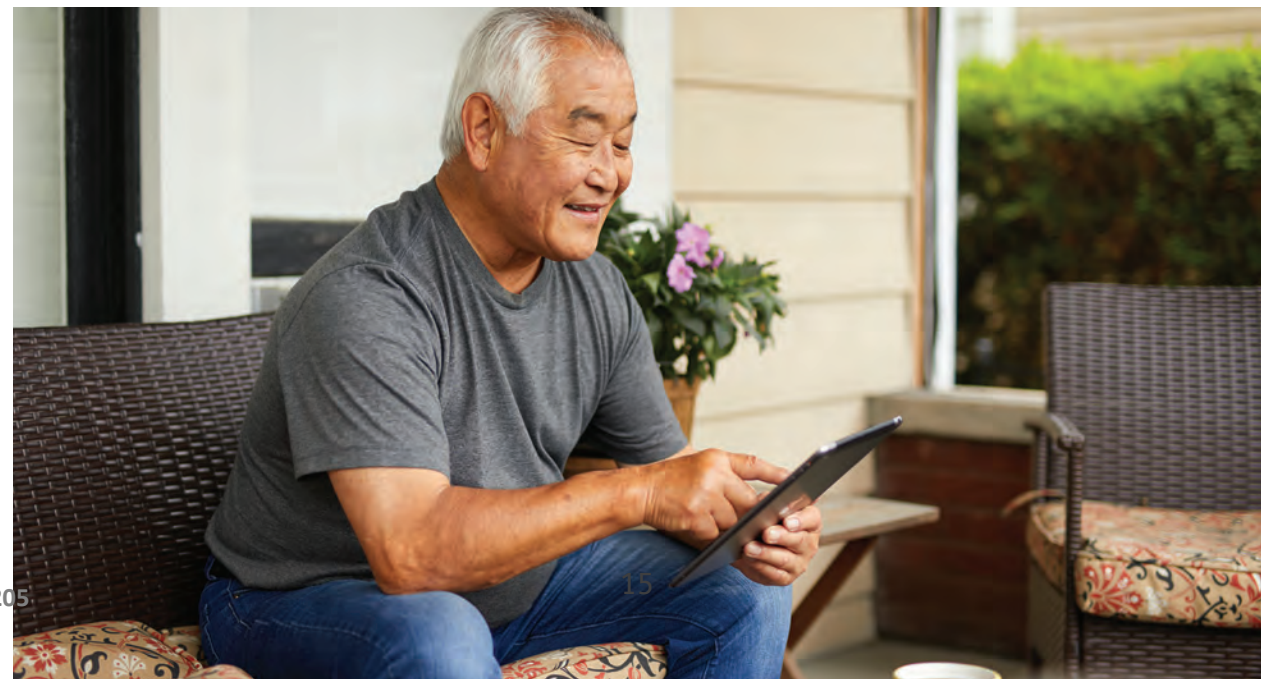
You'll receive this statement after each month you've had a claim. You can also sign in to MyHumana and see your past SmartSummary statements anytime.

SmartSummary helps you:

- Understand your total healthcare picture
- Manage your monthly and yearly healthcare costs
- Engage with your providers by having a list of the healthcare services you receive
- Learn about preventive care, health conditions, treatment options and ways to help reduce health expenses

SmartSummary includes:

- Numbers to watch – SmartSummary shows your total drug costs for the month and year-to-date. It also shows how much of these costs your plan paid and how much you paid—so you can see the value of your prescription benefits.
- Personalized messages – SmartSummary gives you tips on saving money on the prescription drugs you take, information about changes in prescription copayments and how to plan ahead.
- Your Rx record – A personalized prescription manager tells you more about your prescription medications, including information about dosage and the prescribing provider. It also has a refill calendar that helps you know the date of your next refill. This page can be useful to take to your provider appointments or to your pharmacist.
- Healthcare news relevant for you – SmartSummary personalizes a news section to let you know about things you can do for your health, including medications and treatments for health problems.



Do I need to show my red, white and blue Medicare card when I visit the doctor?

No. You'll get a Humana member ID card that will take its place. Keep your Medicare ID card in a safe place—or use it only when it's needed for discounts and other offers from retailers.

What should I do if I move or have a temporary address change?

If you move to another area or state, it may affect your plan. It's important to contact your group benefits administrator for details and call to notify Humana of the move.

What should I do if I have to file a claim?

Call Humana Group Medicare Customer Care for more information and assistance. To request reimbursement for a charge you paid for a service, send the provider's itemized receipt and the Health Benefits Claim Form (also available at **Humana.com**) to the claims address on the back of your Humana member ID card. Make sure the receipt includes your name and Humana member ID number.

What if I have other health insurance coverage?

If you have other health insurance, show your Humana member ID card and your other insurance cards when you see a healthcare provider. The Humana Group Medicare plan may be eligible in combination with other types of health insurance coverage you may have. This is called coordination of benefits. Please notify Humana if you have any other medical coverage.

When does my coverage begin?

Your former employer or union decides how and when you enroll. Check with your benefits administrator for the proposed effective date of your enrollment. Be sure to keep your current healthcare coverage until your Humana Group Medicare HMO plan enrollment is confirmed.

What if my service needs a prior authorization?

If your medical service or medication requires a prior authorization, your provider can contact Humana to request it. You can call Customer Care if you have questions regarding what medical services and medications require prior authorization.

What should I do if I need prescriptions filled before I receive my Humana member ID card?

If you need to fill a prescription after your coverage begins but before you receive your Humana member ID card, take a copy of your temporary proof of membership to any in-network pharmacy.

How can I get help with my drug plan costs?

People with limited incomes may qualify for assistance from the Extra Help program to pay for their prescription drug costs. To see if you qualify for Extra Help, call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. If you use a TTY, call **1-877-486-2048**. You can also call the Social Security Administration at **1-800-772-1213**. If you use a TTY, call **1-800-325-0778**. Your state's Medical Assistance (Medicaid) Office may also be able to help, or you can apply for Extra Help online at **www.socialsecurity.gov**.

Coinsurance

Your share of the cost after deductible
A percentage of your medical and drug costs that you may pay out of your pocket for services after you pay any plan deductible.

Copayment

What you pay at the provider's office for medical services
The set dollar amount you pay when you receive medical services or have a prescription filled.

Deductible

What you pay up front
The amount you pay for healthcare before your plan begins to pay for your benefits.

Exclusions and limitations

Anything not covered or covered under limited situations or conditions
Specific conditions or circumstances that aren't covered under a plan.

Maximum out-of-pocket

The most you'll spend before your plan pays 100% of the cost
The most you would have to pay for services covered by a health plan, including deductibles, copays and coinsurance. If and when you reach your annual out-of-pocket limit, the Humana Group Medicare plan pays 100% of the Medicare-approved amount for most covered medical charges.

Network

Your plan's contracted medical providers
A group of healthcare providers contracted to provide medical services at discounted rates. The providers include doctors, hospitals and other healthcare professionals and facilities.

Plan discount

A way Humana helps you save money
Amount you are not responsible for due to Humana's negotiated rate with provider.

Premium

The regular monthly payment for your plan
The amount you and/or your employer regularly pay for Medicare or Medicare Advantage coverage.

Catastrophic coverage

What you pay for covered drugs after reaching $7,050
Once your out-of-pocket costs reach the $7,050 maximum, you pay a small coinsurance or a small copayment for covered drug costs until the end of the plan year.

Coinsurance

Your share of your prescription's cost
This is a percentage of the total cost of a drug you pay each time you fill a prescription.

Copayment

What you pay at the pharmacy for your prescription
The set dollar amount you pay when you fill a prescription.

Deductible

Your cost for Part D prescription drugs before the plan pays
The amount you pay for Part D prescription drugs before the plan begins to pay its share.

Exclusions and limitations

Anything not covered
Specific conditions or circumstances that aren't covered under a plan.

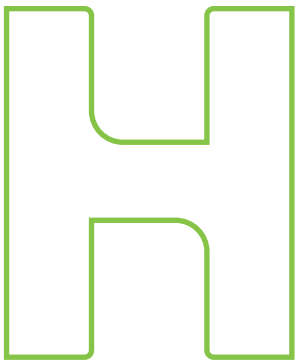
Formulary

Drugs covered under your plan
A list of drugs approved for coverage under the plan. Also called a Drug List.

Out-of-pocket

Portion of costs you pay
Amount you may have to pay for most plans, including deductibles, copays and coinsurance.

NOTES



Humana®

A more human way
to healthcare™

Humana.

Only for Humana members

A fun way to earn rewards for making healthier choices

go365 by Humana™

Welcome to Go365 by Humana®, the wellness program that rewards you for completing eligible healthy activities.

It's part of your Humana Medicare Advantage plan

Your health can be rewarding

Go365 by Humana makes wellness fun and easy. We can help you reach your physical and emotional health goals. Track your activity and redeem rewards:

- online, at **MyHumana.com**
- by filling out and mailing in paper forms

Staying connected socially is important to your overall health and well-being. Social and cognitive activities can help contribute to better long-term mental health, and may help ward off dementia and depression.[1,2]

Earn rewards you can redeem for gift cards

More healthy activites = more gift cards for you

Complete eligible healthy activities like walking, getting your Annual Wellness Visit or volunteering and you can earn rewards to redeem for gift cards. Once you've earned at least $10 in rewards, choose your gift cards in the Go365 Mall.

Activate your Go365 Profile

Now it's time to get going with Go365

If you have a MyHumana account, you can use the same information to log in to **Go365.com**. If not, activate your profile at MyHumana.com. Once you log into Go365, you'll see eligible activities you can complete to earn rewards and details on how to track your actions.

Track your exercise program the easy way

Earn $5 in rewards a month for completing 8 workouts, or $10 in rewards for completing 16 workouts. Here are three easy ways to track and earn:

1. **Attend a participating SilverSneakers® Fitness class** to earn rewards automatically if your plan includes SilverSneakers. Your rewards may take up to 45 days to show up in your Go365 account.
2. **Log your workouts online** in your Go365 account or use a paper workout tracker to record your exercise. Eligible activites include taking a fitness class or exercise on your own—it just needs to be a minimum of 500 steps.
3. **Connect a compatible activity tracker to Go365,** then log at least 500 steps a day and earn automatic rewards for device workouts.

Go365 is compatible with activity trackers from a variety of manufacturers like Fitbit and Garmin. For a full list, sign in to your Go365 account.

Stay connected with Go365.
Visit **Go365.com/MedicareCommunity.**

Activity	Reward*	Activity limit
GET HEALTHY: Preventive screenings		
Annual Wellness Visit	$25	1 per year
Mammogram	$30	1 per year
Colorectal screening Ages 50+	$30	1 per year**
Cardiovascular disease screening	$10	1 per year**
Bone density screening	$20	once every 2 years**
Flu shot	$10	1 per year
Your reward will show up automatically in your Go365 account if billed through your Humana medical or pharmacy plan. This can take up to 90 days.		
GET INVOLVED: Social and educational activities		
Attend a class or health education seminar offered by Humana Neighborhood Center or groups in your community. Examples may include a painting, dancing or nutrition class (in person or online)	$5	12 times per year ($60 annual maximum)
Complete an athletic event (e.g., 5k walk/run, cycling, tournament)	$5	
Volunteer	$5	
Attend a social club such as garden, book, religious, or sports/golf/pickleball/walking, etc. (virutal or in person)	$5	
Post or comment in the Go365 Member Community	$5	
Video or phone call (3 times) with friends or family	$5	
Discuss health, or play a game with friends or family (3 times)	$5	
Other fitness event (e.g. dance competition, bocce ball tournament)	$5	
GET ACTIVE: Exercise and fitness		
8-15 workouts per month—SilverSneakers, connected activity tracker or paper fitness tracker (minimum of 500 steps/day)	$5	Once per month ($120 annual maximum)
16 or more workouts per month	$10	

[1]"Global Health and Aging." World Health Organization, 2011. https://www.who.int/ageing/publications/global_health.pdf.

[2]"Loneliness and Social Isolation Linked to Serious Health Conditions." Centers for Disease Control and Prevention. https://www.cdc.gov/aging/publications/features/lonely-older-adults.html.

*Amounts shown represent the value of the reward, not actual dollars.

**If applicable.

Rewards have no cash value and can only be redeemed in the Go365 Mall. Rewards must be earned and redeemed within the same program year. Rewards not redeemed before Dec. 31 will be forfeited. Some items may be discontinued in the Go365 Mall and new items may be added. For the most updated list, visit **Go365.com** or call **866-677-0999 (TTY: 711)**. In accordance with the federal requirement of the Centers for Medicare & Medicaid Services, no amounts on the gift cards shall be used to purchase prescription drugs or medical services that are covered by Medicare, Medicaid or other federal healthcare programs; nor shall they be used to purchase alcohol, tobacco, e-cigarettes or firearms. Gift cards cannot be converted to cash.

2022

Prescription Drug Guide

Humana Medicare Employer Plan Abbreviated Formulary

Partial list of covered drugs

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN.

2

This abridged formulary was updated on 04/06/2022 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan with any questions at the number on the back of your membership card or for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com.**

Instructions for getting information about all covered drugs are inside.

Humana®

Welcome to The Humana Medicare Employer Plan!

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan," it means the Humana Medicare Employer Plan. This document includes a partial list of the drugs (formulary) for our plan which is current as of April 2022. For a complete, updated formulary, please contact us on our website at **Humana.com/PlanDocuments** or you can call the number below to request a paper copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1 of each year, and from time to time during the year.

What is the abridged Humana Medicare Employer formulary?
A formulary is the entire list of covered drugs or medicines selected by the Humana Medicare Employer Plan. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. The Humana Medicare Employer Plan worked with a team of doctors and pharmacists to make a formulary that represents the prescription drugs we think you need for a quality treatment program. The Humana Medicare Employer Plan will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Humana Medicare Employer Plan network pharmacy, and other plan rules are followed. For more information on how to fill your medicines, please review your Evidence of Coverage.

This document is a partial formulary, which means it includes only some of the drugs covered by the Humana Medicare Employer Plan. To search the complete list of all prescription drugs Humana covers, you can visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

If you are thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, please contact Group Medicare Customer Care number listed in your enrollment materials. If you are a current member, call the number or visit the website listed in your Annual Notice of Change (ANOC) or Evidence of Coverage (EOC), or call the number on the back of your Humana member identification card. Our live representatives are available from 8 a.m. to 9 p.m. (EST), Monday through Friday. Our automated phone system is available after hours, weekends, and holidays.

Can the formulary change?
Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs**. We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled "How do I request an exception to the Formulary?"
- **Drugs removed from the market**. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes**. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

We will notify members who are affected by the following changes to the formulary:
- When a drug is removed from the formulary
- When prior authorization, quantity limits, or step-therapy restrictions are added to a drug or made more restrictive
- When a drug is moved to a higher cost sharing tier

If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled "How do I request an exception to the Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

What if you are affected by a Drug List change?
We will notify you by mail at least 30 days before one of these changes happens or we will provide a 30-day refill of the affected medicine with notice of the change.

The enclosed formulary is current as of April 2022. We will update the printed formularies each month and they will be available on **Humana.com/medicaredruglist**.

To get updated information about the drugs that Humana covers, please visit **Humana.com/medicaredruglist.** The Drug List Search tool lets you search for your drug by name or drug type.

How do I use the formulary?
There are two ways to find your drug in the formulary:

Medical condition
The formulary starts on page 10. We have put the drugs into groups depending on the type of medical conditions that they are used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 10. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 5 for more information on Utilization Management Requirements).

Alphabetical listing
If you are not sure about your drug's group, you should look for your drug in the Index that begins on page 32. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

Prescription drugs are grouped into one of four tiers.
The Humana Medicare Employer Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

- **Tier 1 - Generic or Preferred Generic:** Generic or brand drugs that are available at the lowest cost share for the plan
- **Tier 2 - Preferred Brand:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Generic or Preferred Generic, and at a lower cost to you than Tier 3 Non-Preferred Drug
- **Tier 3 - Non-Preferred Drug:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 2 Preferred Brand drug
- **Tier 4 - Specialty Tier:** Some injectables and other high-cost drugs

How much will I pay for covered drugs?
The Humana Medicare Employer Plan pays part of the costs for your covered drugs and you pay part of the costs, too.

The amount of money you pay depends on:

- Which tier your drug is on
- Whether you fill your prescription at a network pharmacy
- Your current drug payment stage - please read your Evidence of Coverage (EOC) for more information

If you qualified for extra help with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage (EOC) or call Group Medicare Customer Care to find out what your costs are.

Are there any restrictions on my coverage?
Some covered drugs may have additional requirements or limits on coverage. These are called Utilization Management Requirements. These requirements and limits may include:

- **Prior Authorization (PA):** The Humana Medicare Employer Plan requires you to get prior authorization for certain drugs to be covered under your plan. This means that you will need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. If you do not get approval, the Humana Medicare Employer Plan may not cover the drug.
- **Quantity Limits (QL):** For some drugs, the Humana Medicare Employer Plan limits the amount of the drug that is covered. The Humana Medicare Employer Plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Some drugs are limited to a 30-day supply regardless of tier placement.
- **Step Therapy (ST):** In some cases, the Humana Medicare Employer Plan requires that you first try certain drugs to treat your medical condition before coverage is available for another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Medicare Employer Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Medicare Employer Plan will then cover Drug B.
- **Part B versus Part D (B vs D):** Some drugs may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted to the Humana Medicare Employer Plan that describes the use and the place where you receive and take the drug so a determination can be made.

For drugs that need prior authorization or step therapy, or drugs that fall outside of quantity limits, your health care provider can fax information about your condition and need for those drugs to the Humana Medicare Employer Plan at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 10.

You can also visit **Humana.com/medicaredruglist** to get more information about the restrictions applied to specific covered drugs.

You can ask the Humana Medicare Employer Plan to make an exception to these restrictions or limits. See the section "**How do I request an exception to the formulary?**" on page 6 for information about how to request an exception.

What if my drug is not on the formulary?
If your drug is not included in this list of covered drugs, visit **Humana.com/medicaredruglist** to see if your plan covers your drug. You can also call Group Medicare Customer Care and ask if your drug is covered.

If the Humana Medicare Employer Plan does not cover your drug, you have two options:
- You can ask Group Medicare Customer Care for a list of similar drugs that the Humana Medicare Employer Plan covers. Show the list to your doctor and ask him or her to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

Talk to your health care provider to decide if you should switch to another drug that is covered or if you should request a formulary exception so that it can be considered for coverage.

How do I request an exception to the formulary?
You can ask the Humana Medicare Employer Plan to make an exception to the coverage rules. There are several types of exceptions that you can ask to be made.
- **Formulary exception:** You can request that your drug be covered if it is not on the formulary. If approved, this drug will be covered at a pre-determined cost sharing level, and you would not be able to ask us to provide the drug at a lower cost sharing level.
- **Utilization restriction exception:** You can request coverage restrictions or limits not be applied to your drug. For example, if your drug has a quantity limit, you can ask for the limit not to be applied and to cover more doses of the drug.
- **Tier exception:** You can request a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can request it to be covered as a preferred drug instead. This would lower how much money you must pay for your drug. Please remember a higher level of coverage cannot be requested for the drug if approval was granted to cover a drug that was not on the formulary. *You can ask us to cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier.*

Generally, the Humana Medicare Employer Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost sharing drug, or other restrictions would not be as effective in treating your health condition and/or would cause adverse medical effects.

You should contact us to ask for an initial coverage decision for a formulary, tier, or utilization restriction exception.

When you ask for an exception, you should submit a statement from your health care provider that supports your request. This is called a supporting statement.

Generally, we must make the decision within 72 hours of receiving your health care provider's supporting statement. You can request a fast, or expedited, exception if you or your health care provider thinks your health would seriously suffer if you wait as long as 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your health care provider's supporting statement.

Will my plan cover my drugs if they are not on the formulary?
You may take drugs that your plan does not cover. Or you may talk to your provider about taking a different drug that your plan covers, but that drug might have a Utilization Management Requirement, such as a Prior

Authorization or Step Therapy, that keeps you from getting the drug right away. In certain cases, we may cover as much as a 30-day supply of your drug during the first 90 days you are a member of the plan.

Here is what we will do for each of your current Part D drugs that are not on the formulary, or if you have limited ability to get your drugs:
- We will temporarily cover a 30-day supply of your drug unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 30 days of a drug) when you go to a pharmacy.
- There will be no coverage for the drugs after your first 30-day supply, even if you have been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you are a resident of a long-term care facility and you take Part D drugs that are not on the formulary, we will cover a 31-day supply unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 31 days of a drug) during the first 90 days you are a member of our plan. We will cover a 31-day emergency supply of your drug unless you have a prescription for fewer days (in which we will allow multiple fills to provide up to a total of 31 days of a drug) while you request a formulary exception if:

- You need a drug that is not on the formulary *or*
- You have limited ability to get your drugs *and*
- You are past the first 90 days of membership in the plan

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes include:
- Members who are discharged from a hospital or skilled-nursing facility to a home setting
- Members who are admitted to a hospital or skilled-nursing facility from a home setting
- Members who transfer from one skilled-nursing facility to another and use a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- Members who give up Hospice Status and go back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, the Humana Medicare Employer Plan will cover as much as a 31-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. The Humana Medicare Employer Plan will review requests for continuation of therapy on a case-by-case basis understanding when you are on a stabilized drug regimen that, if changed, is known to have risks.

Transition extension
The Humana Medicare Employer Plan will consider on a case-by-case basis an extension of the transition period if your exception request or appeal has not been processed by the end of your initial transition period. We will continue to provide necessary drugs to you if your transition period is extended.

A Transition Policy is available on Humana's Medicare website, **Humana.com**, in the same area where the Prescription Drug Guides are displayed.

Mail order pharmacies make it easy to manage your prescriptions
You may fill your medicines at any network pharmacy, Humana Pharmacy – Humana's mail-delivery pharmacy is one option. To get started or learn more, visit **humanapharmacy.com**. You can also call Humana Pharmacy at **1-844-222-2151** (**TTY: 711**) Monday – Friday, 8 a.m. to 11 p.m., and Saturday, 8 a.m. to 6:30 p.m.

Other pharmacies are available in our network.

For More Information

For more detailed information about your Humana Medicare Employer Plan prescription drug coverage, please read your Evidence of Coverage (EOC) and other plan materials.

If you have questions about Humana, please visit our website at **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

If you have general questions about Medicare prescription drug coverage, please call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**. You can also visit **www.medicare.gov**.

Humana Medicare Employer Plan Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by the Humana Medicare Employer Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 32.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug is not listed in this partial formulary, please visit our website at **Humana.com**. Our additional contact information is listed on the previous page.

How to read your formulary
The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand-name drugs are CAPITALIZED and generic drugs are listed in lower-case italics. Next to the drug name or Utilization Management column, you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:
DL - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
MO - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.
LA - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.

The second column lists the tier of the drug. See page 5 for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. The Humana Medicare Employer Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 5 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Analgesics		
acetaminophen-cod #3 tablet **DL**	1	QL (360 per 30 days)
BELBUCA 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG, BUCCAL FILM **DL**	3	QL (60 per 30 days)
celecoxib 100 mg, 200 mg, 400 mg, 50 mg, capsule **MO**	1	QL (60 per 30 days)
diclofenac sod ec 25 mg, 50 mg, 75 mg, tab **MO**	1	
diclofenac sodium 1% gel **MO**	1	
fentanyl 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour, patch; fentanyl 37.5 mcg/hr patch; fentanyl 62.5 mcg/hr patch; fentanyl 87.5 mcg/hr patch **DL**	1	QL (20 per 30 days)
hydrocodone-acetamin 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg,; hydrocodone-acetamin 2.5-325; hydrocodone-acetamin 7.5-325 **DL**	1	QL (360 per 30 days)
ibuprofen 400 mg, 600 mg, 800 mg, tablet **MO**	1	
meloxicam 15 mg, tablet **MO**	1	QL (30 per 30 days)
meloxicam 7.5 mg, tablet **MO**	1	QL (60 per 30 days)
morphine sulf er 15 mg, 30 mg, 60 mg, tablet **DL**	1	QL (120 per 30 days)
naproxen 250 mg, 375 mg, 500 mg, tablet; naproxen dr 250 mg, 375 mg, 500 mg, tablet **MO**	1	
oxycodone hcl (ir) 10 mg, 15 mg, 20 mg, 30 mg, 5 mg, tab; oxycodone hcl (ir) 10 mg, 15 mg, 20 mg, 30 mg, 5 mg, tablet **DL**	1	QL (360 per 30 days)
oxycodone-acetaminophen 10-325; oxycodone-acetaminophen 5-325; oxycodone-acetaminophn 2.5-325; oxycodone-acetaminophn 7.5-325 **DL**	1	QL (360 per 30 days)
tramadol hcl 50 mg, tablet **DL**	1	QL (240 per 30 days)
XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG, CAPSULE SPRINKLE **DL**	2	QL (60 per 30 days)
Anesthetics		
lidocaine 5% patch **MO**	1	PA,QL (90 per 30 days)
lidocaine-prilocaine cream **MO**	1	
Anti-Addiction/Substance Abuse Treatment Agents		
NARCAN 4 MG/ACTUATION, NASAL SPRAY **MO**	2	QL (2 per 30 days)
VIVITROL 380 MG, INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE **DL**	4	QL (1 per 28 days)
ZUBSOLV 0.7 MG-0.18 MG SUBLINGUAL TABLET; ZUBSOLV 1.4 MG-0.36 MG SUBLINGUAL TABLET; ZUBSOLV 2.9 MG-0.71 MG SUBLINGUAL TABLET; ZUBSOLV 5.7 MG-1.4 MG SUBLINGUAL TABLET **MO**	1	QL (90 per 30 days)
ZUBSOLV 11.4 MG-2.9 MG SUBLINGUAL TABLET **MO**	1	QL (30 per 30 days)
ZUBSOLV 8.6 MG-2.1 MG SUBLINGUAL TABLET **MO**	1	QL (60 per 30 days)
Antibacterials		
amoxicillin 250 mg, 500 mg, capsule **MO**	1	
amox-clav 250-125 mg, 500-125 mg, 875-125 mg, tablet **MO**	1	

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B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
azithromycin 250 mg, 500 mg, 600 mg, tablet **MO**	1	
BETHKIS 300 MG/4 ML, SOLUTION FOR NEBULIZATION **DL**	4	PA
cefdinir 300 mg, capsule **MO**	1	
cephalexin 250 mg, 500 mg, 750 mg, capsule **MO**	1	
ciprofloxacin hcl 100 mg, 250 mg, 500 mg, 750 mg, tab **MO**	1	
clindamycin hcl 150 mg, 300 mg, 75 mg, capsule **MO**	1	
daptomycin 350 mg, 500 mg, vial **DL**	4	
DIFICID 200 MG, TABLET **DL**	4	
DIFICID 40 MG/ML, ORAL SUSPENSION **DL**	4	
doxycycline hyclate 100 mg, 50 mg, cap **MO**	1	
imipenem-cilastatin 250 mg, 500 mg, vl **MO**	1	
levofloxacin 250 mg, 500 mg, 750 mg, tablet **MO**	1	
meropenem iv 1 gm vial; meropenem iv 1 gram, 500 mg, vial **MO**	1	
meropenem-0.9% nacl 1 gram/50; meropenem-0.9% nacl 500 mg/50 **MO**	1	
metronidazole 250 mg, 500 mg, tablet **MO**	1	
nafcillin 1 gm add-van vial; nafcillin 1 gm vial; nafcillin 10 gm bulk vial; nafcillin 2 gm add-vant vial; nafcillin 2 gm vial **MO**	1	
nafcillin 1 gm/ 50 ml inj; nafcillin 2 gm/ 100 ml inj **DL**	4	
nitrofurantoin mono-mcr 100 mg, **MO**	1	
NUZYRA 100 MG, INTRAVENOUS SOLUTION **DL**	4	
NUZYRA 150 MG, TABLET **DL**	4	QL (30 per 14 days)
piperacil-tazobact 13.5 gm vl; piperacil-tazobact 13.5 gram, 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram,; piperacil-tazobact 2.25 gm vl; piperacil-tazobact 3.375 gm vl; piperacil-tazobact 4.5 gm vial **MO**	1	
polymyxin b sulfate vial **MO**	1	
sulfamethoxazole-tmp ds tablet; sulfamethoxazole-tmp ss tablet **MO**	1	
TOBI 300 MG/5 ML, SOLUTION FOR NEBULIZATION **DL**	4	PA
vanco 1 gram/200 ml, 500 mg/100 ml, 750 mg/150 ml,-0.9% nacl; vancomycin 1 g/200ml-0.9% nacl **MO**	3	
ANTICONVULSANTS		
divalproex sod dr 125 mg, 250 mg, 500 mg, tab **MO**	1	
divalproex sod er 250 mg, 500 mg, tab **MO**	1	
EPIDIOLEX 100 MG/ML, ORAL SOLUTION **DL**	4	PA
gabapentin 100 mg, 300 mg, 400 mg, capsule **MO**	1	QL (270 per 30 days)
gabapentin 600 mg, 800 mg, tablet **MO**	1	QL (180 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
lamotrigine 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14), tablet; lamotrigine odt 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14), tablet; lamotrigine odt kit (blue); lamotrigine odt kit (green); lamotrigine odt kit (orange); lamotrigine tab start kit-blue; lamotrigine tab start kt-green; lamotrigine tab start kt-orang **MO**	1	
levetiracetam 1,000 mg, 500 mg, 750 mg, tablet **MO**	1	
topiramate 100 mg, 200 mg, 50 mg, tablet **MO**	1	QL (120 per 30 days)
VIMPAT 10 MG/ML, ORAL SOLUTION **MO**	3	QL (1395 per 30 days)
VIMPAT 100 MG, 150 MG, 200 MG, 50 MG, TABLET **MO**	3	QL (60 per 30 days)
VIMPAT 200 MG/20 ML, INTRAVENOUS SOLUTION **MO**	3	
Antidementia Agents		
donepezil hcl 10 mg, 23 mg, 5 mg, tablet; donepezil hcl odt 10 mg, 23 mg, 5 mg, tablet **MO**	1	QL (30 per 30 days)
donepezil hcl 10 mg, tablet **MO**	1	QL (60 per 30 days)
memantine hcl 10 mg, 5 mg, tablet **MO**	1	PA,QL (60 per 30 days)
NAMZARIC 14 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 21 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 28 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 7 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG, CAPSULE,SPRINKLE,EXTEND RELEASE,DOSE PACK **MO**	2	QL (28 per 28 days)
Antidepressants		
amitriptyline hcl 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg, tab **MO**	1	
bupropion hcl sr 150 mg, tablet **MO**	1	QL (90 per 30 days)
bupropion hcl xl 300 mg, tablet **MO**	1	QL (60 per 30 days)
citalopram hbr 10 mg, 40 mg, tablet **MO**	1	QL (30 per 30 days)
citalopram hbr 20 mg, tablet **MO**	1	QL (60 per 30 days)
duloxetine hcl dr 20 mg, 40 mg, 60 mg, cap **MO**	1	QL (60 per 30 days)
duloxetine hcl dr 30 mg, cap **MO**	1	QL (90 per 30 days)
escitalopram 10 mg, tablet **MO**	1	QL (45 per 30 days)
fluoxetine hcl 10 mg, 40 mg, capsule **MO**	1	QL (60 per 30 days)
fluoxetine hcl 20 mg, capsule **MO**	1	QL (120 per 30 days)
mirtazapine 15 mg, 30 mg, 45 mg, 7.5 mg, tablet **MO**	1	
paroxetine hcl 10 mg, 20 mg, tablet **MO**	1	QL (30 per 30 days)
paroxetine hcl 30 mg, 40 mg, tablet **MO**	1	QL (60 per 30 days)
sertraline hcl 100 mg, tablet **MO**	1	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
sertraline hcl 25 mg, 50 mg, tablet **MO**	1	QL (90 per 30 days)
trazodone 100 mg, 150 mg, 300 mg, 50 mg, tablet **MO**	1	
TRINTELLIX 10 MG, 20 MG, 5 MG, TABLET **MO**	3	ST,QL (30 per 30 days)
venlafaxine hcl er 150 mg, cap **MO**	1	QL (60 per 30 days)
venlafaxine hcl er 75 mg, cap **MO**	1	QL (90 per 30 days)
Antiemetics		
meclizine 12.5 mg, 25 mg, tablet **MO**	1	
ondansetron odt 4 mg, 8 mg, tablet **MO**	1	B vs D,QL (90 per 30 days)
ondansetron hcl 4 mg, 8 mg, tablet **MO**	1	B vs D,QL (90 per 30 days)
promethazine 12.5 mg, 25 mg, 50 mg, tablet **MO**	1	
SANCUSO 3.1 MG/24 HOUR, TRANSDERMAL PATCH **MO**	3	QL (4 per 30 days)
Antifungals		
clotrimazole-betamethasone crm **MO**	1	QL (180 per 30 days)
fluconazole 100 mg, 150 mg, 200 mg, 50 mg, tablet **MO**	1	
ketoconazole 2% shampoo **MO**	1	QL (120 per 30 days)
nystatin 100,000 unit/gm cream **MO**	1	
Antigout Agents		
allopurinol 100 mg, 300 mg, tablet **MO**	1	
MITIGARE 0.6 MG, CAPSULE **MO**	2	
ANTIMIGRAINE AGENTS		
AIMOVIG AUTOINJECTOR 140 MG/ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	3	PA,QL (1 per 30 days)
AIMOVIG AUTOINJECTOR 70 MG/ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	3	PA,QL (2 per 30 days)
EMGALITY PEN 120 MG/ML, SUBCUTANEOUS PEN INJECTOR **MO**	3	PA,QL (2 per 30 days)
EMGALITY 120 MG/ML, SUBCUTANEOUS SYRINGE **MO**	3	PA,QL (2 per 30 days)
EMGALITY 300 MG/3 ML (100 MG/ML X 3), SUBCUTANEOUS SYRINGE **MO**	3	PA,QL (3 per 30 days)
sumatriptan succ 100 mg, 25 mg, 50 mg, tablet **MO**	1	QL (9 per 30 days)
Antimyasthenic Agents		
MESTINON TIMESPAN 180 MG, TABLET,EXTENDED RELEASE **DL**	4	PA
pyridostigmine 60 mg/5 ml, soln **MO**	1	
pyridostigmine br 30 mg, 60 mg, tablet **MO**	1	
pyridostigmine er 180 mg, tab **MO**	1	
Antimycobacterials		
rifabutin 150 mg, capsule **MO**	1	
RIFADIN 600 MG, INTRAVENOUS SOLUTION **MO**	3	
rifampin 150 mg, 300 mg, capsule **MO**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Antineoplastics		
AFINITOR 10 MG, 2.5 MG, 5 MG, 7.5 MG, TABLET **DL**	4	PA,QL (30 per 30 days)
AFINITOR DISPERZ 2 MG, 3 MG, 5 MG, TABLET FOR ORAL SUSPENSION **DL**	4	PA
ALUNBRIG 180 MG, 90 MG, 90 MG (7)- 180 MG (23), TABLET; ALUNBRIG 90 MG (7)-180 MG (23) TABLETS IN A DOSE PACK **DL**	4	PA,QL (30 per 30 days)
ALUNBRIG 30 MG, TABLET **DL**	4	PA,QL (180 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG, TABLET **DL**	4	PA,QL (30 per 30 days)
ERIVEDGE 150 MG, CAPSULE **DL**	4	PA,QL (28 per 28 days)
ERLEADA 60 MG, TABLET **DL**	4	PA,QL (120 per 30 days)
HERCEPTIN 150 MG, 420 MG, INTRAVENOUS SOLUTION; HERCEPTIN 150 MG, 420 MG, VIAL **DL**	4	PA
HERCEPTIN HYLECTA 600 MG-10,000 UNIT/5 ML, SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (5 per 21 days)
IBRANCE 100 MG, 125 MG, 75 MG, CAPSULE **DL**	4	PA,QL (21 per 28 days)
IBRANCE 100 MG, 125 MG, 75 MG, TABLET **DL**	4	PA,QL (21 per 28 days)
IMBRUVICA 140 MG, CAPSULE **DL**	4	PA,QL (90 per 30 days)
IMBRUVICA 420 MG, 560 MG, TABLET **DL**	4	PA,QL (28 per 28 days)
IMBRUVICA 70 MG, CAPSULE **DL**	4	PA,QL (28 per 28 days)
NUBEQA 300 MG, TABLET **DL**	4	PA,QL (120 per 30 days)
RITUXAN 10 MG/ML, CONCENTRATE,INTRAVENOUS **DL**	4	PA
SPRYCEL 100 MG, 50 MG, 70 MG, 80 MG, TABLET **DL**	4	PA,QL (60 per 30 days)
SPRYCEL 140 MG, TABLET **DL**	4	PA,QL (30 per 30 days)
SPRYCEL 20 MG, TABLET **DL**	4	PA,QL (90 per 30 days)
TYKERB 250 MG, TABLET **DL**	4	PA,QL (180 per 30 days)
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG, TABLET **DL**	4	PA,QL (60 per 30 days)
XTANDI 40 MG, CAPSULE **DL**	4	PA,QL (120 per 30 days)
Antiparasitics		
hydroxychloroquine 100 mg, 200 mg, 300 mg, 400 mg, tab **MO**	1	
ivermectin 3 mg, tablet **MO**	1	
ANTIPARKINSON AGENTS		
benztropine mes 0.5 mg, 1 mg, 2 mg, tab; benztropine mes 0.5 mg, 1 mg, 2 mg, tablet **MO**	1	
carbidopa-levo 10-100 mg, 25-100 mg, 25-250 mg, odt; carbidopa-levodopa 10-100 tab; carbidopa-levodopa 25-100 tab; carbidopa-levodopa 25-250 tab **MO**	1	
KYNMOBI 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG, SUBLINGUAL FILM; KYNMOBI 10 MG-15 MG-20 MG-25 MG-30 MG SUBLINGUAL FILM **DL**	4	PA,QL (150 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NEUPRO 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR, TRANSDERMAL 24 HOUR PATCH **MO**	3	QL (30 per 30 days)
pramipexole 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, tablet **MO**	1	
ropinirole hcl 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg, tablet **MO**	1	
RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE; RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE **MO**	3	ST,QL (360 per 30 days)
RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE **MO**	3	ST,QL (270 per 30 days)
RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE **MO**	3	ST,QL (300 per 30 days)
Antipsychotics		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG, TABLET **DL**	4	PA
ABILIFY MAINTENA 300 MG, 400 MG, INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE **DL**	4	QL (1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG, SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE **DL**	4	QL (1 per 28 days)
ABILIFY MYCITE 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG, TABLET WITH SENSOR AND PATCH **DL**	4	PA,QL (30 per 30 days)
aripiprazole 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg, tablet **MO**	1	
ARISTADA 1,064 MG/3.9 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **MO**	4	QL (3.9 per 56 days)
ARISTADA 441 MG/1.6 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (1.6 per 28 days)
ARISTADA 662 MG/2.4 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (2.4 per 28 days)
ARISTADA 882 MG/3.2 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML, SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	QL (2.4 per 42 days)
INVEGA 1.5 MG, 3 MG, 9 MG, TABLET,EXTENDED RELEASE **DL**	4	PA,QL (30 per 30 days)
INVEGA 6 MG, TABLET,EXTENDED RELEASE **DL**	4	PA,QL (60 per 30 days)
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML, INTRAMUSCULAR SYRINGE **DL**	4	QL (1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML, INTRAMUSCULAR SYRINGE **DL**	4	QL (1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML, INTRAMUSCULAR SYRINGE **MO**	3	QL (1.5 per 28 days)
INVEGA TRINZA 273 MG/0.88 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (0.88 per 90 days)
INVEGA TRINZA 410 MG/1.32 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (1.32 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (1.75 per 90 days)
INVEGA TRINZA 819 MG/2.63 ML, INTRAMUSCULAR SYRINGE **MO**	4	QL (2.63 per 90 days)
olanzapine 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg, tablet **MO**	1	
PERSERIS 120 MG, 90 MG, ABDOMINAL SUBCUTANEOUS EXT. RELEASE SUSPENSION SYRINGE **DL**	4	QL (1 per 28 days)
quetiapine fumarate 200 mg, 25 mg, 50 mg, tab **MO**	1	QL (120 per 30 days)
REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG, TABLET **MO**	3	PA,QL (30 per 30 days)
RISPERDAL 0.5 MG, TABLET **MO**	3	QL (120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RISPERDAL 1 MG, 2 MG, 3 MG, 4 MG, TABLET DL	4	QL (60 per 30 days)
RISPERDAL 1 MG/ML, ORAL SOLUTION DL	4	
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML, INTRAMUSCULAR SUSP,EXTENDED RELEASE MO	3	QL (2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML, INTRAMUSCULAR SUSP,EXTENDED RELEASE DL	4	QL (2 per 28 days)
risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg, odt; risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg, tablet MO	1	QL (60 per 30 days)
Antispasticity Agents		
baclofen 10 mg, 20 mg, tablet MO	1	
dantrolene sodium 100 mg, 25 mg, 50 mg, cap MO	1	
tizanidine hcl 2 mg, 4 mg, tablet MO	1	
ANTIVIRALS		
acyclovir 400 mg, 800 mg, tablet MO	1	
BIKTARVY 30 MG-120 MG-15 MG TABLET; BIKTARVY 50 MG-200 MG-25 MG TABLET DL	4	QL (30 per 30 days)
DESCOVY 120 MG-15 MG TABLET; DESCOVY 200 MG-25 MG TABLET DL	4	QL (30 per 30 days)
EPCLUSA 200 MG-50 MG TABLET; EPCLUSA 400 MG-100 MG TABLET DL	4	PA,QL (28 per 28 days)
GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET DL	4	QL (30 per 30 days)
HARVONI 33.75 MG-150 MG ORAL PELLETS IN PACKET DL	4	PA,QL (28 per 28 days)
HARVONI 45 MG-200 MG ORAL PELLETS IN PACKET DL	4	PA,QL (56 per 28 days)
HARVONI 45 MG-200 MG TABLET; HARVONI 90 MG-400 MG TABLET DL	4	PA,QL (28 per 28 days)
ledipasvir-sofosbuvir 90-400mg DL	4	PA,QL (28 per 28 days)
ODEFSEY 200 MG-25 MG-25 MG TABLET DL	4	QL (30 per 30 days)
oseltamivir phos 45 mg, 75 mg, capsule MO	1	QL (112 per 365 days)
VOSEVI 400 MG-100 MG-100 MG TABLET DL	4	PA,QL (28 per 28 days)
XOFLUZA 20 MG, 40 MG, TABLET MO	3	QL (10 per 365 days)
Anxiolytics		
alprazolam 0.25 mg, 0.5 mg, 1 mg, tablet DL	1	QL (120 per 30 days)
buspirone hcl 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg, tablet MO	1	
clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg odt; clonazepam 0.5 mg, 1 mg, 2 mg tablet DL	1	
diazepam 2 mg, 5 mg, tablet DL	1	QL (90 per 30 days)
hydroxyzine hcl 10 mg, 25 mg, 50 mg, tablet MO	1	
lorazepam 0.5 mg, 1 mg, tablet DL	1	QL (90 per 30 days)
Bipolar Agents		
lithium carbonate 150 mg, 300 mg, 600 mg, cap MO	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
lithium carbonate 300 mg, tab MO	1	
lithium carbonate er 300 mg, 450 mg, tb MO	1	
LITHOBID 300 MG, TABLET,EXTENDED RELEASE DL	4	
Blood Glucose Regulators		
BAQSIMI 3 MG/ACTUATION, NASAL SPRAY MO	2	
BYDUREON 2 MG PEN INJECT MO	3	QL (4 per 28 days)
BYDUREON BCISE 2 MG/0.85 ML, SUBCUTANEOUS AUTO-INJECTOR MO	3	QL (3.4 per 28 days)
FARXIGA 10 MG, 5 MG, TABLET MO	3	QL (30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN MO	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS CARTRIDGE MO	2	
FIASP U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION MO	2	
glimepiride 1 mg, 2 mg, 4 mg, tablet MO	1	
glipizide 10 mg, 5 mg, tablet MO	1	
glipizide er 10 mg, 2.5 mg, 5 mg, tablet MO	1	
GLUCAGEN HYPOKIT 1 MG, INJECTION MO	2	
GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET MO	2	QL (30 per 30 days)
GVOKE HYPOPEN 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS AUTO-INJECTOR MO	2	
GVOKE PFS 1-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS SYRINGE MO	2	
GVOKE PFS 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS SYRINGE MO	2	
HUMALOG JUNIOR KWIKPEN (U-100) 100 UNIT/ML, SUBCUTANEOUS HALF-UNIT PEN MO	3	ST
HUMALOG KWIKPEN (U-100) INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML), SUBCUTANEOUS; HUMALOG KWIKPEN U-200 INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML), SUBCUTANEOUS MO	3	ST
HUMALOG MIX 50-50 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO	3	ST
HUMALOG MIX 50-50 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN MO	3	ST
HUMALOG MIX 75-25 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN MO	3	ST
HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS CARTRIDGE MO	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION MO	3	ST

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO**	3	ST
HUMULIN 70/30 U-100 INSULIN KWIKPEN 100 UNIT/ML SUBCUTANEOUS **MO**	3	ST
HUMULIN N NPH U-100 INSULIN KWIKPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS **MO**	3	ST
HUMULIN N NPH U-100 INSULIN (ISOPHANE SUSP) 100 UNIT/ML, SUBCUTANEOUS **MO**	3	ST
HUMULIN R REGULAR U-100 INSULIN 100 UNIT/ML, INJECTION SOLUTION **MO**	3	ST
HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML, SUBCUTANEOUS SOLN **DL**	4	
HUMULIN R U-500 (CONC) INSULIN KWIKPEN 500 UNIT/ML (3 ML), SUBCUTANEOUS **DL**	4	
INSULIN ASPART PRO MIX70-30 PN **MO**	2	
INSULIN ASPART PRO MIX70-30 VL **MO**	2	
INSULIN ASPART 100 UNIT/ML PEN **MO**	2	
INSULIN ASPART 100 UNIT/ML, CRT **MO**	2	
INSULIN ASPART 100 UNIT/ML, VL **MO**	2	
INSULIN LISPRO 100 UNIT/ML, PEN; INSULIN LISPRO JR 100 UNIT/ML, **MO**	3	ST
INSULIN LISPRO 100 UNIT/ML, VL **MO**	3	ST
INSULIN LISPRO MIX 75-25 KWKPN **MO**	3	ST
INVOKAMET 150 MG-1,000 MG TABLET; INVOKAMET 150 MG-500 MG TABLET; INVOKAMET 50 MG-1,000 MG TABLET; INVOKAMET 50 MG-500 MG TABLET **MO**	2	QL (60 per 30 days)
INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
INVOKANA 100 MG, 300 MG, TABLET **MO**	2	QL (30 per 30 days)
JANUMET 50 MG-1,000 MG TABLET; JANUMET 50 MG-500 MG TABLET **MO**	2	QL (60 per 30 days)
JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE; JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG, TABLET **MO**	2	QL (30 per 30 days)
JARDIANCE 10 MG, 25 MG, TABLET **MO**	2	QL (30 per 30 days)
JENTADUETO 2.5 MG-1,000 MG TABLET; JENTADUETO 2.5 MG-500 MG TABLET; JENTADUETO 2.5 MG-850 MG TABLET **MO**	2	QL (60 per 30 days)
JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE **MO**	3	QL (60 per 30 days)
KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE; KOMBIGLYZE XR 5 MG-500 MG TABLET,EXTENDED RELEASE **MO**	3	QL (30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
LANTUS U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
LEVEMIR FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
LEVEMIR U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS **MO**	3	ST
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML), SUBCUTANEOUS **MO**	3	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	3	ST
metformin hcl 1,000 mg, 500 mg, 850 mg, tablet **MO**	1	
metformin hcl er 500 mg, tablet **MO**	1	QL (120 per 30 days)
NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30), SUBCUTANEOUS **MO**	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO**	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN **MO**	2	
NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML, SUBCUTANEOUS SUSP **MO**	2	
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN **MO**	2	
NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML, INJECTION SOLUTION **MO**	2	
NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML), SUBCUTANEOUS **MO**	2	
NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION **MO**	2	
NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN **MO**	2	
NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML, SUBCUTANEOUS CARTRIDG **MO**	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
ONGLYZA 2.5 MG, 5 MG, TABLET **MO**	3	QL (30 per 30 days)
OZEMPIC 0.25 MG OR 0.5 MG (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (1.5 per 28 days)
OZEMPIC 1 MG/DOSE (2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), SUBCUTANEOUS PEN INJECTOR; OZEMPIC 1 MG/DOSE (2 MG/1.5ML) **MO**	2	QL (3 per 28 days)
pioglitazone hcl 15 mg, 30 mg, 45 mg, tablet **MO**	1	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RYBELSUS 14 MG, 3 MG, 7 MG, TABLET **MO**	2	QL (30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML, SUBCUTANEOUS INSULIN PEN **MO**	2	QL (15 per 24 days)
SYNJARDY 12.5 MG-1,000 MG TABLET; SYNJARDY 12.5 MG-500 MG TABLET; SYNJARDY 5 MG-1,000 MG TABLET; SYNJARDY 5 MG-500 MG TABLET **MO**	2	QL (60 per 30 days)
SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN **MO**	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML), SUBCUTANEOUS PEN **MO**	2	
TRADJENTA 5 MG, TABLET **MO**	2	QL (30 per 30 days)
TRESIBA FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
TRESIBA FLEXTOUCH U-200 INSULIN 200 UNIT/ML (3 ML), SUBCUTANEOUS PEN **MO**	2	
TRESIBA U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION **MO**	2	
TRIJARDY XR 10 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE; TRIJARDY XR 25 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
TRIJARDY XR 12.5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE; TRIJARDY XR 5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE **MO**	2	QL (60 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML, SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (2 per 28 days)
VICTOZA 2-PAK 0.6 MG/0.1 ML (18 MG/3 ML), SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (9 per 30 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML), SUBCUTANEOUS PEN INJECTOR **MO**	2	QL (9 per 30 days)
XIGDUO XR 10 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 10 MG-500 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-500 MG TABLET,EXTENDED RELEASE **MO**	3	QL (30 per 30 days)
XIGDUO XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE **MO**	3	QL (60 per 30 days)
XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN **MO**	2	QL (15 per 30 days)
BLOOD PRODUCTS AND MODIFIERS		
BRILINTA 60 MG, 90 MG, TABLET **MO**	2	QL (60 per 30 days)
clopidogrel 75 mg, tablet **MO**	1	QL (30 per 30 days)
ELIQUIS 2.5 MG, TABLET **MO**	2	QL (60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ELIQUIS 5 MG, TABLET **MO**	2	QL (74 per 30 days)
ELIQUIS DVT-PE TREATMENT 30-DAY STARTER 5 MG (74 TABLETS) IN DOSE PACK **MO**	2	QL (74 per 30 days)
enoxaparin 100 mg/ml, 150 mg/ml, syringe **MO**	1	QL (28 per 28 days)
enoxaparin 120 mg/0.8 ml, 80 mg/0.8 ml, syr **MO**	1	QL (22.4 per 28 days)
enoxaparin 30 mg/0.3 ml, 60 mg/0.6 ml, syr **MO**	1	QL (16.8 per 28 days)
enoxaparin 300 mg/3 ml, vial **MO**	1	QL (84 per 28 days)
enoxaparin 40 mg/0.4 ml, syr **MO**	1	QL (11.2 per 28 days)
NEULASTA 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.2 per 28 days)
NEULASTA ONPRO 6 MG/0.6 ML, WITH WEARABLE SUBCUTANEOUS INJECTOR **DL**	4	PA,QL (1.2 per 28 days)
NEUPOGEN 300 MCG/0.5 ML, INJECTION SYRINGE **DL**	4	PA,QL (7 per 30 days)
NEUPOGEN 300 MCG/ML, INJECTION SOLUTION **DL**	4	PA,QL (14 per 30 days)
NEUPOGEN 480 MCG/0.8 ML, INJECTION SYRINGE **DL**	4	PA,QL (11.2 per 30 days)
NEUPOGEN 480 MCG/1.6 ML, INJECTION SOLUTION **DL**	4	PA,QL (22.4 per 30 days)
NIVESTYM 300 MCG/0.5 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (7 per 30 days)
NIVESTYM 300 MCG/ML, INJECTION SOLUTION **DL**	4	PA,QL (14 per 30 days)
NIVESTYM 480 MCG/0.8 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (11.2 per 30 days)
NIVESTYM 480 MCG/1.6 ML, INJECTION SOLUTION **DL**	4	PA,QL (22.4 per 30 days)
PRADAXA 110 MG, 150 MG, 75 MG, CAPSULE **MO**	3	QL (60 per 30 days)
PROMACTA 12.5 MG, 75 MG, TABLET **DL, LA**	4	PA,QL (60 per 30 days)
PROMACTA 12.5 MG, ORAL POWDER PACKET **DL, LA**	4	PA,QL (360 per 30 days)
PROMACTA 25 MG, ORAL POWDER PACKET **DL, LA**	4	PA,QL (180 per 30 days)
PROMACTA 25 MG, TABLET **DL, LA**	4	PA,QL (30 per 30 days)
PROMACTA 50 MG, TABLET **DL, LA**	4	PA,QL (90 per 30 days)
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML, INJECTION SOLUTION **MO**	3	PA,QL (14 per 30 days)
UDENYCA 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.2 per 28 days)
warfarin sodium 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg, tablet **MO**	1	
XARELTO 10 MG, 20 MG, TABLET **MO**	2	QL (30 per 30 days)
XARELTO 15 MG, 2.5 MG, TABLET **MO**	2	QL (60 per 30 days)
XARELTO DVT-PE TREATMENT 30-DAY STARTER 15 MG(42)-20 MG(9) TABLET PACK **MO**	2	QL (51 per 30 days)
ZARXIO 300 MCG/0.5 ML, INJECTION SYRINGE **DL**	4	PA,QL (7 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ZARXIO 480 MCG/0.8 ML, INJECTION SYRINGE **DL**	4	PA,QL (11.2 per 30 days)
ZIEXTENZO 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.2 per 28 days)
CARDIOVASCULAR AGENTS		
amiodarone hcl 100 mg, 200 mg, tablet **MO**	1	
amlodipine besylate 10 mg, 2.5 mg, 5 mg, tab **MO**	1	
amlodipine-benazepril 10-20 mg, 2.5-10 mg, 5-10 mg, 5-20 mg,; amlodipine-benazepril 2.5-10 **MO**	1	QL (60 per 30 days)
atenolol 100 mg, 25 mg, 50 mg, tablet **MO**	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg, tablet **MO**	1	
benazepril hcl 10 mg, 20 mg, 40 mg, 5 mg, tablet **MO**	1	
bumetanide 0.5 mg, 1 mg, 2 mg, tablet **MO**	1	
BYSTOLIC 10 MG, TABLET **MO**	2	QL (120 per 30 days)
BYSTOLIC 2.5 MG, 5 MG, TABLET **MO**	2	QL (30 per 30 days)
BYSTOLIC 20 MG, TABLET **MO**	2	QL (60 per 30 days)
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg, tablet **MO**	1	
chlorthalidone 25 mg, 50 mg, tablet **MO**	1	
clonidine hcl 0.1 mg, 0.2 mg, 0.3 mg, tablet **MO**	1	
CORLANOR 5 MG, 7.5 MG, TABLET **MO**	3	PA,QL (60 per 30 days)
CORLANOR 5 MG/5 ML, ORAL SOLUTION **MO**	3	PA,QL (560 per 28 days)
digoxin 125 mcg tablet; digoxin 250 mcg tablet; digoxin 62.5 mcg tablet **MO**	1	QL (30 per 30 days)
diltiazem 24h er(cd) 120 mg, 180 mg, 240 mg, cp; diltiazem 24hr er 120 mg, 180 mg, 240 mg, cap **MO**	1	QL (60 per 30 days)
doxazosin mesylate 1 mg, 2 mg, 4 mg, 8 mg, tab **MO**	1	
enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg, tab; enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg, tablet **MO**	1	
ENTRESTO 24 MG-26 MG TABLET; ENTRESTO 49 MG-51 MG TABLET; ENTRESTO 97 MG-103 MG TABLET **MO**	2	QL (60 per 30 days)
ezetimibe 10 mg, tablet **MO**	1	QL (30 per 30 days)
fenofibrate 120 mg, 160 mg, tablet **MO**	1	QL (30 per 30 days)
furosemide 20 mg, 40 mg, 80 mg, tablet **MO**	1	
hydralazine 10 mg, 100 mg, 25 mg, 50 mg, tablet **MO**	1	
hydrochlorothiazide 12.5 mg, 25 mg, 50 mg, tab; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg, tb **MO**	1	
irbesartan 150 mg, 300 mg, 75 mg, tablet **MO**	1	QL (30 per 30 days)
isosorbide mononit er 120 mg, 30 mg, 60 mg,; isosorbide mononit er 120 mg, 30 mg, 60 mg, tb **MO**	1	
lisinopril 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg, tablet **MO**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
lisinopril-hctz 10-12.5 mg, 20-12.5 mg, 20-25 mg, tab **MO**	1	
losartan potassium 100 mg, 25 mg, 50 mg, tab **MO**	1	QL (60 per 30 days)
losartan-hctz 100-12.5 mg, 100-25 mg, 50-12.5 mg, tab **MO**	1	QL (60 per 30 days)
lovastatin 10 mg, 20 mg, 40 mg, tablet **MO**	1	
metoprolol succ er 100 mg, 200 mg, 50 mg, tab **MO**	1	QL (60 per 30 days)
metoprolol succ er 25 mg, tab **MO**	1	QL (90 per 30 days)
metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg, tab; metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg, tb **MO**	1	
MULTAQ 400 MG, TABLET **MO**	2	QL (60 per 30 days)
NEXLETOL 180 MG, TABLET **MO**	2	PA,QL (30 per 30 days)
NEXLIZET 180 MG-10 MG TABLET **MO**	2	PA,QL (30 per 30 days)
nifedipine er 30 mg, 60 mg, 90 mg, tablet **MO**	1	QL (60 per 30 days)
nitroglycerin 0.3 mg, 0.4 mg, 0.6 mg, tablet sl **MO**	1	
olmesartan medoxomil 20 mg, 40 mg, 5 mg, tab **MO**	1	QL (30 per 30 days)
pravastatin sodium 10 mg, 20 mg, 40 mg, 80 mg, tab **MO**	1	
propranolol 10 mg, 20 mg, 40 mg, 60 mg, 80 mg, tablet **MO**	1	
ramipril 1.25 mg, 10 mg, 2.5 mg, 5 mg, capsule **MO**	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML, SUBCUTANEOUS WEARABLE INJECTOR **MO**	2	PA,QL (3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML, SUBCUTANEOUS PEN INJECTOR **MO**	2	PA,QL (3 per 28 days)
REPATHA SYRINGE 140 MG/ML, SUBCUTANEOUS SYRINGE **MO**	2	PA,QL (3 per 28 days)
rosuvastatin calcium 10 mg, 20 mg, 40 mg, 5 mg, tab **MO**	1	
simvastatin 10 mg, 20 mg, 40 mg, 5 mg, 80 mg, tablet **MO**	1	
spironolactone 100 mg, 25 mg, 50 mg, tablet **MO**	1	
TEKTURNA 150 MG, 300 MG, TABLET **MO**	3	PA,QL (30 per 30 days)
TEKTURNA HCT 150 MG-12.5 MG TABLET; TEKTURNA HCT 150 MG-25 MG TABLET; TEKTURNA HCT 300 MG-12.5 MG TABLET; TEKTURNA HCT 300 MG-25 MG TABLET **MO**	3	ST,QL (30 per 30 days)
torsemide 10 mg, 100 mg, 20 mg, 5 mg, tablet **MO**	1	
triamterene-hctz 37.5-25 mg, 75-50 mg, tab; triamterene-hctz 37.5-25 mg, 75-50 mg, tb **MO**	1	
valsartan 160 mg, 320 mg, 40 mg, 80 mg, tablet **MO**	1	QL (60 per 30 days)
VASCEPA 0.5 GRAM, CAPSULE **MO**	2	QL (240 per 30 days)
VASCEPA 1 GRAM, CAPSULE **MO**	2	QL (120 per 30 days)
WELCHOL 3.75 GRAM, ORAL POWDER PACKET **MO**	3	QL (30 per 30 days)
WELCHOL 625 MG, TABLET **MO**	3	QL (180 per 30 days)
ZYPITAMAG 2 MG, 4 MG, TABLET **MO**	2	ST,QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
CENTRAL NERVOUS SYSTEM AGENTS		
AUSTEDO 12 MG, 9 MG, TABLET **DL**	4	PA,QL (120 per 30 days)
AUSTEDO 6 MG, TABLET **DL**	4	PA,QL (60 per 30 days)
BETASERON 0.3 MG, SUBCUTANEOUS KIT **DL**	4	PA,QL (15 per 30 days)
COPAXONE 20 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (30 per 30 days)
COPAXONE 40 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (12 per 28 days)
dextroamp-amphetam 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg, tab; dextroamp-amphetamin 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg, tab; dextroamp-amphetamine 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg, tab **MO**	1	QL (90 per 30 days)
GILENYA 0.25 MG, 0.5 MG, CAPSULE **DL**	4	PA,QL (30 per 30 days)
pregabalin 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg, capsule **MO**	1	QL (90 per 30 days)
SAVELLA 100 MG, 12.5 MG, 12.5 MG (5)-25 MG(8)-50 MG(42), 25 MG, 50 MG, TABLET; SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK **MO**	2	QL (60 per 30 days)
TECFIDERA 120 MG (14)- 240 MG (46), 240 MG, CAPSULE,DELAYED RELEASE; TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE **DL**	4	PA,QL (60 per 30 days)
TECFIDERA 120 MG, CAPSULE,DELAYED RELEASE **DL**	4	PA,QL (14 per 30 days)
Dental & Oral Agents		
chlorhexidine 0.12% rinse **MO**	1	
triamcinolone 0.1% paste **MO**	1	
DERMATOLOGICAL AGENTS		
ENSTILAR 0.005 %-0.064 % TOPICAL FOAM **MO**	3	QL (120 per 30 days)
hydrocortisone 1% cream; hydrocortisone 2.5% cream **MO**	1	QL (240 per 30 days)
mupirocin 2% ointment **MO**	1	
PICATO 0.015% GEL **MO**	4	QL (3 per 30 days)
PICATO 0.05% GEL **MO**	4	QL (2 per 30 days)
REGRANEX 0.01 %, TOPICAL GEL **DL**	4	PA
SANTYL 250 UNIT/GRAM, TOPICAL OINTMENT **MO**	2	QL (180 per 30 days)
TACLONEX 0.005 %-0.064 % TOPICAL OINTMENT **DL**	4	PA,QL (60 per 30 days)
TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION **MO**	4	PA,QL (420 per 30 days)
Electrolytes/Minerals/Metals/Vitamins		
AURYXIA 210 MG IRON, TABLET **MO**	3	PA,QL (360 per 30 days)
EXJADE 125 MG, 250 MG, 500 MG, DISPERSIBLE TABLET **DL**	4	PA
JADENU 180 MG, 360 MG, 90 MG, TABLET **DL**	4	PA
JADENU SPRINKLE 180 MG, 360 MG, 90 MG, ORAL GRANULES IN PACKET **DL**	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
LOKELMA 10 GRAM, 5 GRAM, ORAL POWDER PACKET **MO**	2	QL (30 per 30 days)
potassium cl er 10 meq, 15 meq, 20 meq, tablet **MO**	1	
GASTROINTESTINAL AGENTS		
DEXILANT 30 MG, 60 MG, CAPSULE, DELAYED RELEASE **MO**	3	QL (30 per 30 days)
dicyclomine 10 mg, capsule **MO**	1	
esomeprazole mag dr 20 mg, 40 mg, cap **MO**	1	QL (60 per 30 days)
famotidine 20 mg, 40 mg, tablet **MO**	1	
LINZESS 145 MCG, 290 MCG, 72 MCG, CAPSULE **MO**	2	QL (30 per 30 days)
MOVANTIK 12.5 MG, 25 MG, TABLET **MO**	2	QL (30 per 30 days)
omeprazole dr 10 mg, 20 mg, 40 mg, capsule **MO**	1	QL (60 per 30 days)
pantoprazole sod dr 20 mg, 40 mg, tab **MO**	1	QL (60 per 30 days)
PYLERA 140 MG-125 MG-125 MG CAPSULE **MO**	3	QL (120 per 30 days)
RELISTOR 12 MG/0.6 ML, SUBCUTANEOUS SOLUTION **MO**	3	QL (36 per 30 days)
RELISTOR 12 MG/0.6 ML, SUBCUTANEOUS SYRINGE **MO**	3	QL (36 per 28 days)
RELISTOR 150 MG, TABLET **MO**	3	QL (90 per 30 days)
RELISTOR 8 MG/0.4 ML, SUBCUTANEOUS SYRINGE **MO**	3	QL (12 per 30 days)
sucralfate 1 gm tablet **MO**	1	
SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION **MO**	2	
SUTAB 1.479-0.188-0.225 GRAM TABLET **MO**	3	
XIFAXAN 200 MG, TABLET **DL**	4	PA,QL (9 per 30 days)
XIFAXAN 550 MG, TABLET **DL**	4	PA,QL (84 per 28 days)
GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
CERDELGA 84 MG, CAPSULE **DL**	4	PA
CEREZYME 400 UNIT, INTRAVENOUS SOLUTION **DL**	4	PA
CREON 12,000-38,000-60,000 UNIT CAPSULE,DELAYED RELEASE; CREON 24,000-76,000-120,000 UNIT CAPSULE,DELAYED RELEASE; CREON 3,000 UNIT-9,500 UNIT-15,000 UNIT CAPSULE,DELAYED RELEASE; CREON 36,000 UNIT-114,000 UNIT-180,000 UNIT CAPSULE,DELAYED RELEASE; CREON 6,000-19,000-30,000 UNIT CAPSULE,DELAYED RELEASE **MO**	2	
ELELYSO 200 UNIT, INTRAVENOUS SOLUTION **DL**	4	PA
ONPATTRO 2 MG/ML, INTRAVENOUS SOLUTION **MO**	4	PA
PROLASTIN-C 1,000 MG (+/-)/20 ML INTRAVENOUS SOLUTION; PROLASTIN-C 1,000 MG, 1,000 MG (+/-)/20 ML, INTRAVENOUS POWDER FOR SOLUTION **DL**	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML, SUBCUTANEOUS SOLUTION **DL**	4	PA
ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE **MO**	3	
Genitourinary Agents		
finasteride 5 mg, tablet **MO**	1	QL (30 per 30 days)
GEMTESA 75 MG, TABLET **MO**	3	QL (30 per 30 days)
MYRBETRIQ 25 MG, 50 MG, TABLET,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
oxybutynin 5 mg, tablet **MO**	1	
oxybutynin cl er 10 mg, 15 mg, 5 mg, tablet **MO**	1	QL (60 per 30 days)
tamsulosin hcl 0.4 mg, capsule **MO**	1	
TOVIAZ 4 MG, 8 MG, TABLET,EXTENDED RELEASE **MO**	2	QL (30 per 30 days)
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
methylprednisolone 4 mg, dosepk **MO**	1	
prednisone 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg, tablet **MO**	1	B vs D
triamcinolone 0.025% cream; triamcinolone 0.1% cream; triamcinolone 0.5% cream **MO**	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
desmopressin acetate 0.1 mg, tb **MO**	1	QL (180 per 30 days)
desmopressin acetate 0.2 mg, tb **MO**	1	
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML), SUBCUTANEOUS CARTRIDGE **DL**	4	PA
OMNITROPE 5.8 MG, SUBCUTANEOUS SOLUTION **DL**	4	PA
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg, tablet; estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg, vaginal insrt **MO**	1	
OSPHENA 60 MG, TABLET **MO**	2	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG, TABLET **MO**	3	
PREMARIN 0.625 MG/GRAM, VAGINAL CREAM **MO**	2	
PREMARIN 25 MG, SOLUTION FOR INJECTION **MO**	3	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg, tablet **MO**	1	
liothyronine sod 10 mcg/ml, vl **MO**	1	
liothyronine sod 25 mcg, 5 mcg, 50 mcg, tab **MO**	1	
SYNTHROID 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG, TABLET **MO**	2	
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN 500 MG, TABLET **DL**	4	
Hormonal Agents, Suppressant (Pituitary)		
ORGOVYX 120 MG, TABLET **DL**	4	PA,QL (32 per 30 days)
SOMATULINE DEPOT 120 MG/0.5 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (0.5 per 28 days)
SOMATULINE DEPOT 60 MG/0.2 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (0.2 per 28 days)
SOMATULINE DEPOT 90 MG/0.3 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (0.3 per 28 days)
Hormonal Agents, Suppressant (Thyroid)		
methimazole 10 mg, 5 mg, tablet **MO**	1	
TAPAZOLE 10 MG, 5 MG, TABLET **MO**	1	
IMMUNOLOGICAL AGENTS		
COSENTYX 150 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (8 per 28 days)
COSENTYX 300 MG/2 SYRINGES (150 MG/ML,) SUBCUTANEOUS **DL**	4	PA,QL (8 per 28 days)
COSENTYX PEN 150 MG/ML, SUBCUTANEOUS **DL**	4	PA,QL (8 per 28 days)
COSENTYX PEN 300 MG/2 PENS (150 MG/ML,) SUBCUTANEOUS **DL**	4	PA,QL (8 per 28 days)
DUPIXENT 300 MG/2 ML, SUBCUTANEOUS PEN INJECTOR **DL**	4	PA,QL (6 per 28 days)
DUPIXENT 200 MG/1.14 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (3.42 per 28 days)
DUPIXENT 300 MG/2 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (6 per 28 days)
ENBREL 25 MG (1 ML), 25 MG/0.5 ML, SUBCUTANEOUS POWDER FOR SOLUTION; ENBREL 25 MG (1 ML), 25 MG/0.5 ML, SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (8 per 28 days)
ENBREL 25 MG/0.5 ML (0.5 ML) SUBCUTANEOUS SYRINGE; ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML), SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (8 per 28 days)
ENBREL MINI 50 MG/ML (1 ML), SUBCUTANEOUS CARTRIDGE **DL**	4	PA,QL (8 per 28 days)
ENBREL SURECLICK 50 MG/ML (1 ML), SUBCUTANEOUS PEN INJECTOR **DL**	4	PA,QL (8 per 28 days)
ENVARSUS XR 0.75 MG, 1 MG, 4 MG, TABLET,EXTENDED RELEASE **MO**	3	PA
GAMUNEX-C 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %), INJECTION SOLUTION **DL**	4	PA
HIZENTRA 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %), SUBCUTANEOUS SOLUTION **DL**	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMIRA 40 MG/0.8 ML, SUBCUTANEOUS SYRINGE KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML, SUBCUTANEOUS KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML, SUBCUT KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS-ADOL HID SUP START 40 MG/0.8 ML, SUBCUT KT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML, SUBCUTANEOUS SYRINGE KIT **DL**	4	PA,QL (2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML, SUBCUTANEOUS SYRINGE KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEDI CROHN'S START 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML, SUBCUT SYR KIT; HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML, SUBCUT SYRINGE KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML, SUBCUTANEOUS KIT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEN CROHN'S-ULC COLITIS-HID SUP STRT 80 MG/0.8 ML, SUBCUT KT **DL**	4	PA,QL (6 per 28 days)
HUMIRA(CF) PEN PS-UV-ADOL HS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT **DL**	4	PA,QL (6 per 28 days)
INFLECTRA 100 MG, INTRAVENOUS SOLUTION **DL**	4	PA
KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML, SUBCUTANEOUS PEN INJECTOR **DL**	4	PA,QL (2.28 per 28 days)
KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (2.28 per 28 days)
methotrexate 2.5 mg, tablet **MO**	1	B vs D
REMICADE 100 MG, INTRAVENOUS SOLUTION **DL**	4	PA
RINVOQ 15 MG, 30 MG, TABLET,EXTENDED RELEASE **DL**	4	PA,QL (30 per 30 days)
RUCONEST 2,100 UNIT, INTRAVENOUS SOLUTION **DL**	4	PA,QL (8 per 28 days)
SHINGRIX (PF) 50 MCG/0.5 ML, INTRAMUSCULAR SUSPENSION, KIT **DL**	2	
SIMPONI ARIA 12.5 MG/ML, INTRAVENOUS SOLUTION **DL**	4	PA,QL (20 per 28 days)
SKYRIZI 150 MG/1.66 ML(75 MG/0.83 ML X 2) SUBCUTANEOUS SYRINGE KIT; SKYRIZI 150 MG/ML, 150MG/1.66ML(75 MG/0.83 ML X2), SUBCUTANEOUS SYRINGE **MO**	4	PA,QL (6 per 365 days)
STELARA 130 MG/26 ML, INTRAVENOUS SOLUTION **DL**	4	PA,QL (104 per 30 days)
STELARA 45 MG/0.5 ML, SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (1.5 per 84 days)
STELARA 45 MG/0.5 ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.5 per 84 days)
STELARA 90 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (3 per 84 days)
Inflammatory Bowel Disease Agents		
ASACOL HD 800 MG, TABLET,DELAYED RELEASE **DL**	4	ST,QL (180 per 30 days)
mesalamine 800 mg, dr tablet **MO**	1	ST,QL (180 per 30 days)
mesalamine er 0.375 gram, cap **MO**	1	QL (120 per 30 days)
PENTASA 500 MG, CAPSULE,CONTROLLED RELEASE **DL**	4	ST,QL (300 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Metabolic Bone Disease Agents		
alendronate sodium 35 mg, 70 mg, tab **MO**	1	QL (4 per 28 days)
PROLIA 60 MG/ML, SUBCUTANEOUS SYRINGE **MO**	3	QL (1 per 180 days)
RAYALDEE 30 MCG, CAPSULE,EXTENDED RELEASE **DL**	4	QL (60 per 30 days)
TYMLOS 80 MCG/DOSE (3,120 MCG/1.56 ML) SUBCUTANEOUS PEN INJECTOR **MO**	4	PA,QL (1.56 per 30 days)
XGEVA 120 MG/1.7 ML (70 MG/ML), SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (1.7 per 28 days)
Miscellaneous Therapeutic Agents		
BD ALCOHOL SWABS **MO**	1	
OMNIPOD DASH INSULIN POD SUBCUTANEOUS CARTRIDGE **MO**	2	
OMNIPOD INSULIN MANAGEMENT **MO**	2	
OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE **MO**	2	
RECTIV 0.4 % (W/W), OINTMENT **MO**	3	QL (30 per 30 days)
V-GO 20 DEVICE **MO**	2	
V-GO 30 DEVICE **MO**	2	
V-GO 40 DEVICE **MO**	2	
OPHTHALMIC AGENTS		
ALPHAGAN P 0.1 %, EYE DROPS **MO**	2	
ALPHAGAN P 0.15 %, EYE DROPS **MO**	3	PA
brimonidine 0.2% eye drop; brimonidine tartrate 0.15% drp **MO**	1	
COMBIGAN 0.2 %-0.5 % EYE DROPS **MO**	2	QL (5 per 25 days)
dorzolamide-timolol eye drops **MO**	1	
DUREZOL 0.05 %, EYE DROPS **MO**	2	
ILEVRO 0.3 %, EYE DROPS,SUSPENSION **MO**	2	QL (3 per 30 days)
latanoprost 0.005% eye drops **MO**	1	QL (5 per 25 days)
LOTEMAX 0.5 %, EYE DROPS,SUSPENSION; LOTEMAX 0.5 %, EYE GEL DROPS **MO**	3	ST
LOTEMAX 0.5 %, EYE OINTMENT **MO**	3	ST
LOTEMAX SM 0.38 %, EYE GEL DROPS **MO**	3	
LUMIGAN 0.01 %, EYE DROPS **MO**	2	QL (2.5 per 25 days)
PAZEO 0.7% EYE DROPS **MO**	3	QL (2.5 per 25 days)
prednisolone ac 1% eye drop **MO**	1	
RESTASIS 0.05 %, EYE DROPS IN A DROPPERETTE **MO**	2	QL (60 per 30 days)
RESTASIS MULTIDOSE 0.05 %, EYE DROPS **MO**	2	QL (5.5 per 25 days)
RHOPRESSA 0.02 %, EYE DROPS **MO**	2	ST,QL (2.5 per 25 days)
ROCKLATAN 0.02 %-0.005 % EYE DROPS **MO**	2	ST,QL (2.5 per 25 days)
VYZULTA 0.024 %, EYE DROPS **MO**	3	QL (5 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OTIC AGENTS		
ciproflox-dexameth otic susp **MO**	1	
neomycin-polymyxin-hc ear soln **MO**	1	
neomycin-polymyxin-hc ear susp **MO**	1	
ofloxacin 0.3% ear drops **MO**	1	
Respiratory Tract/Pulmonary Agents		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG, TABLET **DL**	4	PA,QL (90 per 30 days)
ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)
ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER **MO**	2	QL (12 per 30 days)
albuterol hfa 90 mcg inhaler **MO**	1	QL (36 per 30 days)
ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION **MO**	3	PA,QL (60 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION, POWDER FOR INHALATION **MO**	2	QL (30 per 30 days)
BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER **MO**	3	QL (10.7 per 30 days)
BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION; BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)
BREZTRI AEROSPHERE 160 MCG-9MCG-4.8MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL (10.7 per 30 days)
COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION **MO**	3	QL (4 per 20 days)
DALIRESP 250 MCG, TABLET **MO**	2	QL (28 per 365 days)
DALIRESP 500 MCG, TABLET **MO**	2	QL (30 per 30 days)
ESBRIET 267 MG, CAPSULE **DL, LA**	4	PA,QL (270 per 30 days)
ESBRIET 267 MG, TABLET **DL, LA**	4	PA,QL (270 per 30 days)
ESBRIET 801 MG, TABLET **DL, LA**	4	PA,QL (90 per 30 days)
FASENRA 30 MG/ML, SUBCUTANEOUS SYRINGE **MO**	4	PA,QL (1 per 28 days)
FASENRA PEN 30 MG/ML, SUBCUTANEOUS AUTO-INJECTOR **MO**	4	PA,QL (1 per 28 days)
FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION, POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)
FLOVENT HFA 110 MCG/ACTUATION, 220 MCG/ACTUATION, AEROSOL INHALER **MO**	2	QL (24 per 30 days)
FLOVENT HFA 44 MCG/ACTUATION, AEROSOL INHALER **MO**	2	QL (10.6 per 30 days)
fluticasone prop 50 mcg spray **MO**	1	QL (16 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
hydroxyzine pam 100 mg, 25 mg, 50 mg, cap **MO**	1	
INCRUSE ELLIPTA 62.5 MCG/ACTUATION, POWDER FOR INHALATION **MO**	3	PA,QL (30 per 30 days)
levocetirizine 5 mg, tablet **MO**	1	QL (30 per 30 days)
montelukast sod 10 mg, tablet **MO**	1	QL (30 per 30 days)
NUCALA 100 MG, 100 MG/ML, SUBCUTANEOUS AUTO-INJECTOR; NUCALA 100 MG, 100 MG/ML, SUBCUTANEOUS SOLUTION **DL**	4	PA,QL (3 per 28 days)
NUCALA 100 MG/ML, SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (3 per 28 days)
OFEV 100 MG, 150 MG, CAPSULE **DL, LA**	4	PA,QL (60 per 30 days)
PERFOROMIST 20 MCG/2 ML, SOLUTION FOR NEBULIZATION **MO**	3	PA,QL (120 per 30 days)
SEREVENT DISKUS 50 MCG/DOSE, POWDER FOR INHALATION **MO**	3	PA,QL (60 per 30 days)
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION, SOLUTION FOR INHALATION **MO**	2	QL (4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG, AND INHALATION CAPSULES **MO**	2	QL (30 per 30 days)
STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO**	2	QL (4 per 28 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION, SOLUTION FOR INHALATION **MO**	2	QL (4 per 30 days)
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL (10.2 per 30 days)
TOBI PODHALER 28 MG, CAPSULE WITH INHALATION DEVICE; TOBI PODHALER 28 MG, INHALE CAP **DL**	4	PA,QL (224 per 28 days)
TRELEGY ELLIPTA 100 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION; TRELEGY ELLIPTA 200 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION **MO**	2	QL (60 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION, AEROSOL INHALER **MO**	2	QL (36 per 30 days)
wixela inhub 100 mcg-50 mcg/dose powder for inhalation; wixela inhub 250 mcg-50 mcg/dose powder for inhalation; wixela inhub 500 mcg-50 mcg/dose powder for inhalation **MO**	1	QL (60 per 30 days)
Skeletal Muscle Relaxants		
cyclobenzaprine 10 mg, 5 mg, tablet **MO**	1	
methocarbamol 500 mg, 750 mg, tablet **MO**	1	
SLEEP DISORDER AGENTS		
BELSOMRA 10 MG, TABLET **MO**	2	QL (60 per 30 days)
BELSOMRA 15 MG, 20 MG, TABLET **MO**	2	QL (30 per 30 days)
BELSOMRA 5 MG, TABLET **MO**	2	QL (120 per 30 days)
temazepam 15 mg, 22.5 mg, 30 mg, 7.5 mg, capsule **DL**	1	QL (30 per 30 days)
zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tab sl; zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tablet sl; zolpidem tart er 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tab; zolpidem tartrate 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg, tablet **MO**	1	QL (30 per 30 days)

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Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD).**
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Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
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العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

This abridged formulary was updated on 04/06/2022 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan with any questions at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com**.

Important Information – Please Read

Humana must receive your application before the effective date you've requested. You can either mail or fax it.

- If mailing your application, please allow 7 days mailing time so we receive your application before the effective date.
- If faxing the application, fax it to **1-877-889-9936** before the effective date. Be sure to keep your fax confirmation as proof of your submission.

Applications not received before your effective date will be processed for the first day of the following month.

Be sure to include the following on your application:

- ☐ Proposed Effective Date
- ☐ Employer or Union Sponsor Name
- ☐ First and Last Name
- ☐ Medicare Claim Number
- ☐ Residential Address
- ☐ Signature of Applicant or POA and Signature Date

Humana®

2022
Enrollment Form

Humana Group Medicare

HMO (Health Maintenance Organization)
A Medicare Advantage plan

Follow these easy steps to become a Humana Medicare member

Have your Medicare card ready

Each individual applying must fill out a separate form.

Sign and date the enrollment form

If the enrollment form is not completed and returned within the allotted time period, the enrollment could be denied.

Please don't send in the same enrollment form or apply to the same plan more than once.

Call us with questions

If you have questions, please call a licensed Humana sales agent at **1-800-824-8242 (TTY: 711)**. We're available Monday - Friday, 8 a.m. – 8 p.m. Eastern Time.

Humana®

Additional Notes

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Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter in each box.
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Correct numbers and letters

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الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Stamp Date

Asterisks (*) indicate required fields

Humana Group Medicare HMO Enrollment Form

EMPLOYER OR UNION SPONSOR NAME* Please use the Employer/Union name listed with your mailing address on your materials.

Please print this information exactly as it is on your Medicare card.

MEDICARE HEALTH INSURANCE

LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO	EFFECTIVE DATE*
HOSPITAL (PART A)	M M – 0 1 – Y Y Y Y
MEDICAL (PART B)	M M – 0 1 – Y Y Y Y

PROPOSED EFFECTIVE DATE*

M M – 0 1 – 2 0 Y Y

PLAN OPTION*

076 /

You can find the option number on the front page of your Summary of Benefits in the bottom right hand corner.

CATEGORY OF ENROLLEE*

- Medicare Eligible Retiree
- Medicare Eligible Spouse
- Medicare Eligible Dependent

DATE OF BIRTH* M M – D D – Y Y Y Y SEX* M F

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.

APT or STE

CITY* ST* ZIP*

COUNTY*

MAILING ADDRESS Your residential address confirms your service area. Print your mailing address/P.O. Box here, if applicable. If your mailing address is your residential address, please fill this oval.

APT or STE

CITY ST ZIP

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

It is important that we can reach you to help you stay informed and take care of your health.
Please provide your telephone number and email address.

TELEPHONE

( ) –

There may be times when Humana will use an automated system to call or text you.
When that happens we will be sure to use the telephone number you provided.

EMAIL By providing your email address, you authorize Humana to send you health information to this address.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

1. If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please fill this oval.* ◯ I will have other prescription drug coverage

Please provide your other prescription drug coverage details here, if applicable.

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

2. Once enrolled, will you or your spouse work? ◯ Yes ◯ No

PRIMARY CARE PHYSICIAN (PCP)*

PCP ID NUMBER*

Are you already a patient of the physician you chose? ◯ Yes ◯ No

You can obtain the PCP ID number on our website at **Humana-medicare.com** or by using the provider directory.

PLEASE READ THIS IMPORTANT INFORMATION

By completing this enrollment form, I agree to the following:
The Humana Group Medicare HMO plan is a Medicare Advantage plan that has a contract with the federal government and I will need to keep my Medicare Parts A and B to stay in the plan. I must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. **I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.** I understand that if I leave this Humana plan, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

I understand that when my Humana coverage begins, I must get all of my medical and prescription drug benefits from Humana. Benefits and services provided by Humana and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Humana will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana as I may have to disenroll and find a new plan in my new area. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that I am enrolling into a Humana Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Release of Information:
By joining this Medicare plan, I acknowledge that Humana will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).

Privacy Act Statement:
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. **Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.**

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Humana the Part D-IRMAA.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE*
M M – D D – 2 0 Y Y

I understand that my signature (or the signature of the individual legally authorized to act on my behalf) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized representative (as described above), the signature certifies that: 1) this individual is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

If you are the authorized legal representative, you **MUST** sign above and provide the following information:*

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE
( ) –

RELATIONSHIP TO APPLICANT

Preferred Language

○ English ○ Spanish ○ Chinese ○ Korean ○ Other _____

If an accessible format is needed, please select one option

○ Audio ○ Large print ○ Accessible screen reader PDF

○ Oral over the phone ○ Braille

Please call a licensed Humana sales agent at **1-800-824-8242 (TTY: 711)** if you need information in another format or language.

INTERNAL MARKETPOINT AGENTS ONLY

WRITING AGENT NAME*

AGENT NUMBER (SAN)*

DATE*
M M – D D – 2 0 Y Y

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

Humana®

Humana.com

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GN85036EN_2022

2022
Enrollment Form

Humana Group Medicare

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A Medicare Advantage plan

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LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO	EFFECTIVE DATE*
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MEDICAL (PART B)	M M – 0 1 – Y Y Y Y

PROPOSED EFFECTIVE DATE*

M M – 0 1 – 2 0 Y Y

PLAN OPTION*

076 /

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CATEGORY OF ENROLLEE*

- Medicare Eligible Retiree
- Medicare Eligible Spouse
- Medicare Eligible Dependent

DATE OF BIRTH* M M – D D – Y Y Y Y SEX* M F

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.

APT or STE

CITY* ST* ZIP*

COUNTY*

MAILING ADDRESS Your residential address confirms your service area. Print your mailing address/P.O. Box here, if applicable. If your mailing address is your residential address, please fill this oval.

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The Humana Group Medicare HMO plan is a Medicare Advantage plan that has a contract with the federal government and I will need to keep my Medicare Parts A and B to stay in the plan. I must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. **I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.** I understand that if I leave this Humana plan, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

I understand that when my Humana coverage begins, I must get all of my medical and prescription drug benefits from Humana. Benefits and services provided by Humana and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Humana will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana as I may have to disenroll and find a new plan in my new area. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that I am enrolling into a Humana Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Release of Information:
By joining this Medicare plan, I acknowledge that Humana will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).

Privacy Act Statement:
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. **Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.**

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Humana the Part D-IRMAA.

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE*
M M – D D – 2 0 Y Y

I understand that my signature (or the signature of the individual legally authorized to act on my behalf) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized representative (as described above), the signature certifies that: 1) this individual is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

If you are the authorized legal representative, you **MUST** sign above and provide the following information:*

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE
( ) –

RELATIONSHIP TO APPLICANT

Preferred Language

○ English ○ Spanish ○ Chinese ○ Korean ○ Other _____

If an accessible format is needed, please select one option

○ Audio ○ Large print ○ Accessible screen reader PDF

○ Oral over the phone ○ Braille

Please call a licensed Humana sales agent at **1-800-824-8242 (TTY: 711)** if you need information in another format or language.

INTERNAL MARKETPOINT AGENTS ONLY

WRITING AGENT NAME*

AGENT NUMBER (SAN)*

DATE*
M M – D D – 2 0 Y Y

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

Humana®

Humana.com

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IN THE
UNITED STATES

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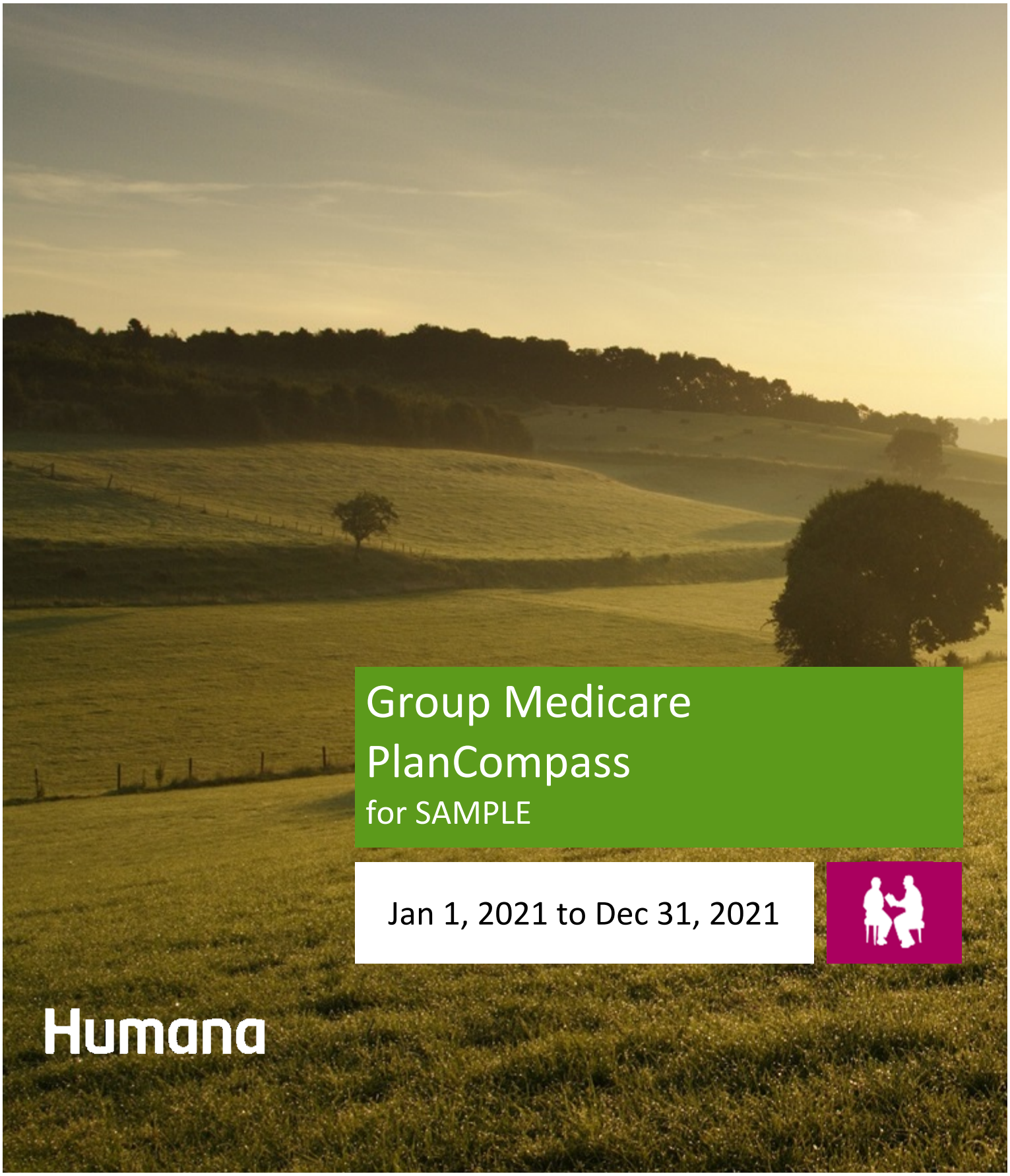
POSTAGE WILL BE PAID BY ADDRESSEE

HUMANA MEDICARE ENROLLMENT
PO BOX 14309
LEXINGTON KY 40512-9801

Attachment C
Sample PlanCompass Reporting Package


Group Medicare
PlanCompass
for SAMPLE
Jan 1, 2021 to Dec 31, 2021
Humana

Parameters - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

	REPORT SELECTION CRITERIA
Report Create Date:	6/15/2022
Reporting Period:	1/1/2021 - 12/31/2021
Paid Data Available Thru:	5/31/2022
Product Segment:	Group Medicare
Line of Business:	PPO
Customer Groups:	ALL Selected
Divisions:	ALL Selected
Benefits:	ALL Selected
Report Sections:	Demographic, Wellness, Spend & Utilization, Pharmacy

Contents - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Report Methodology - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Report Purpose

This PlanCompass report was prepared specifically for your organization to help you stay on top of your group's health care experience. Our desire is that with this PlanCompass - bolstered by the guidance and insights our Sales and Account Management associates deliver - we will be able to help you make the most informed decisions possible about your organization's health, well-being and use of the health care system.

Methodology

PlanCompass uses claim data to report on the important facets of your group's health care experience during the reporting period. PlanCompass reports on an "incurred" basis rather than a "paid/processed basis" to allow for better monitoring of member behavior in response to plan design changes that occur from one plan year to the next. Incurred basis reporting includes only services that were received during the reporting period, regardless of when the claim was paid.

To make the data more meaningful, we frequently report your current period data beside your prior period experience (same reporting period from the prior year) and/or your peer. Including the prior period and peer allows you to see how your group compares to your performance in the prior year and how it compares to other Group Medicare customers (see below for peer details). These comparable numbers add context that can help make sense of what we see.

Pharmacy

The pharmacy data contained in this report includes Part D pharmacy claims, if the group has prescription drug coverage with Humana. Otherwise, the pharmacy data is limited to only Part B pharmacy claims processed by Humana.

Reporting Period

This report is based on incurred claims for the period 01/01/2021 through 12/31/2021, with claims processed through 05/31/2022.

Peer

The peer used for comparison purposes in this report is Humana's PPO (including RPPO, LPPO,and PFFS) Group Medicare Book of Business, excluding your group.

This report was created on 06/15/2022.

Executive Summary - SAMPLE

Reporting Period: 01/01/2021 - 12/31/2021

The Executive Summary is a compilation of what is most important in gauging your group's health plan performance. In the center of the page is the net paid PMPM variance from prior to current year, which is a good indicator of how members are using their healthcare benefits and engaging in wellness. The surrounding metrics are deemed to have the most influence on the PMPM variance. The subsequent pages will include a deeper dive into these categories impacting spend.

Medical Admits / 1,000: **-13.3%** Current: 140 Prior: 162	**Specialty % of RX Net Paid:** **+1.2%** Current: 47.0% Prior: 45.8%	**Prescriptions PMPM:** **-1.1%** Current: 3.07 Prior: 3.10
Large Claimant Spend Impact: **-0.2%** Current: 22.7% Prior: 22.9%	**Net Paid PMPM:** **+7.0%** Current: $1,320.44 Prior: $1,233.49	**Member Cost Share:** **+0.0%** Current: 5.0% Prior: 5.0%
Members with Preventive Services: **+5.1%** Current: 76.1% Prior: 71.0%	**Health Alerts Member Full Compliance:** **-7.8%** Current: 67.0% Prior: 74.8%	**Silver Sneakers Participation %:** **-2.8%** Current: 10.4% Prior: 13.2%

Tips

Education and Communication for the areas with challenges above positively impact the health of your members and the bottom line of the Plan. To help your members become more informed about their health, promote the **Blue Button** available under "MyHealth" on MyHumana at Humana.com. With just a few clicks, members can access a secure copy of their personal health report. Members may choose to access health data for the most current 365 days on topics including Current Conditions, Prescription History, Lab History, and Patient Admission/ER History.

Member Snapshot - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

The Demographic Scorecard demonstrates how your group's membership is broken down. Keep in mind that the average member age and related demographic risk score are typically directly correlated to claims cost.

	Current	Prior	Change	Peer
Average Members	77,149	76,235	1.2%	---
Male/Female Ratio	37/63	37/63	---	42/58
Average Age	74.2	74.0	0.3%	74.3
Demographic Risk Score	3.65	3.62	0.8%	3.69

	Current	Prior	Change	Peer
% Members with Claims	98.9%	98.8%	0.1%	---
% of Large Claimants	1.9%	1.8%	0.1%	---
% Member Cost Share	5.0%	5.0%	0.0%	5.8%

	Current	Prior	Change	Peer
% Members Received Preventive Services	76.1%	71.0%	5.1%	72.9%
% Members with Fully Compliant Health Alerts	67.0%	74.8%	-7.8%	---

	Current	Prior	Change	Peer
% Participation in Silver Sneakers	10.4%	13.2%	-2.8%	10.1%

Tips

Demographics are an excellent way to look at your population and to see which members need the most encouragement and education on how to best utilize their healthcare. Encourage your members to obtain appropriate preventive services and to take action on health alerts sent to them by Humana. The intent of these programs is to catch serious and chronic conditions early when simpler and more cost effective treatments may be available.

As a 65+ population, these members are more likely to experience medical complications which can be very expensive. This makes preventive services key to long-term health and well-being. Pneumococcal vaccines are recommended once per lifetime and colorectal cancer screenings are recommended once over a period of years. As a result, not all members will receive these services in any given year. Humana promotes preventive services through letter and messaging campaigns year-round.

As members age, they typically have more chronic diseases and higher utilization, with more incidences of cancer, heart disease, and age-related conditions, so preventive visits become increasingly important.

	Group		Peer	
% Members With	Current	Prior	Current	Prior
Preventive Services	76.1%	71.0%	72.9%	72.9%
ER Visits	16.7%	15.2%	20.0%	19.6%
Inpatient Admits	10.2%	11.5%	13.6%	13.9%
Prescriptions	97.2%	97.2%	96.3%	96.3%
All Other Medical Services	97.4%	97.0%	96.4%	95.9%

		Period Ending Members		% of Population		% of Spend	
		Current	Prior	Current	Prior	Current	Prior
Adult Females	< 65	1,999	2,165	2.6%	2.8%	4.7%	5.1%
	65 - 69	13,256	13,632	17.0%	17.7%	13.8%	13.8%
	70 - 74	14,262	13,969	18.3%	18.1%	16.5%	15.7%
	75 - 79	9,544	8,887	12.2%	11.5%	11.1%	10.5%
	80 - 84	5,567	5,415	7.1%	7.0%	7.3%	7.0%
	85 - 89	2,939	2,877	3.8%	3.7%	3.6%	3.7%
	90 - 94	1,255	1,223	1.6%	1.6%	1.5%	1.7%
	95+	346	357	0.4%	0.5%	0.4%	0.4%
Adult Males	< 65	1,023	1,108	1.3%	1.4%	2.2%	2.5%
	65 - 69	7,013	7,294	9.0%	9.5%	8.4%	8.9%
	70 - 74	8,809	8,811	11.3%	11.4%	12.2%	12.5%
	75 - 79	6,295	5,951	8.1%	7.7%	9.6%	9.3%
	80 - 84	3,530	3,367	4.5%	4.4%	5.5%	5.6%
	85 - 89	1,609	1,546	2.1%	2.0%	2.6%	2.6%
	90 - 94	469	448	0.6%	0.6%	0.6%	0.7%
	95+	80	84	0.1%	0.1%	0.1%	0.1%

Member Engagement - SAMPLE

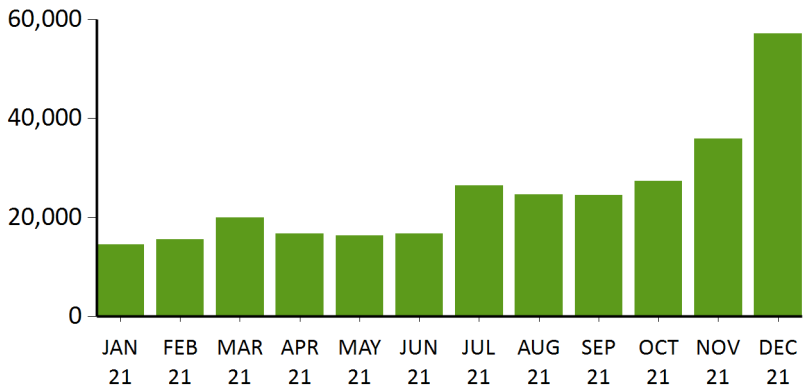
Reporting Period: 01/01/2021 - 12/31/2021

Member Engagement is the key to connecting members to their health. Humana uses a broad spectrum of methods to connect and interact with the member with the sole intent of helping members become healthier and lead a more active lifestyle. Humana's primary means of member contact include phone calls and e-mails. We also encourage members to utilize our self-service tools to learn how their insurance is working for them and all that we offer through MyHumana.com.

Top MyHumana.com Web Pages Visited

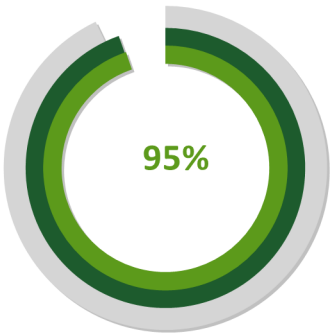
Web Page	% of Use
Go365	53.0%
Claims & Spending	17.7%
Humana Apps View	9.3%
Account Settings	4.5%
Physician Finder	4.0%

of Web Visits



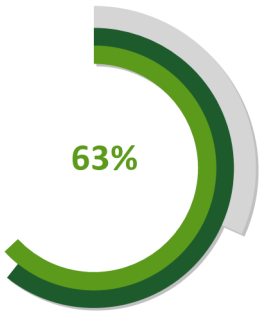
Member Contact

Phone Number on File*



Prior	95%
National Average	93%

e-mail Address on File**



Prior	61%
National Average	32%

MyHumana.com Registrations

Prior	14%
National Average	38%
Target	30%

Current | Prior | Peer

**Phone Number on File is defined as a 10-digit number with a valid area code*

***e-mail Address on File is defined as the employee providing an e-mail address*

Tips

Encouraging members to keep a current phone number and email address on file with Humana, and to register on MyHumana.com, will benefit both the group and the member. Your Humana Representative can offer ideas on retiree education and engagement programs.

Silver Sneakers Utilization Summary - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

SilverSneakers® FITNESS

Utilization by Month

Month	Members	Enrollees*	Participants**	Visits	% of Mbrs Participating	% of Mbrs Enrolled	% of Enrollees Participating	Avg Visits Per Person
1/31/2021	76,716	10,633	2,553	20,688	3.3%	13.9%	24.0%	8.1
2/28/2021	76,541	10,809	2,826	20,748	3.7%	14.1%	26.1%	7.3
3/31/2021	76,519	11,033	3,326	26,332	4.4%	14.4%	30.2%	7.9
4/30/2021	76,491	11,206	3,440	26,045	4.5%	14.7%	30.7%	7.6
5/31/2021	76,498	11,403	3,685	26,630	4.8%	14.9%	32.3%	7.2
6/30/2021	77,036	11,725	4,218	30,651	5.5%	15.2%	36.0%	7.3
7/31/2021	77,303	12,073	4,423	31,798	5.7%	15.6%	36.6%	7.2
8/31/2021	77,424	12,304	4,202	31,784	5.4%	15.9%	34.2%	7.6
9/30/2021	77,450	12,503	4,052	29,843	5.2%	16.1%	32.4%	7.4
10/31/2021	77,864	12,730	4,222	30,147	5.4%	16.4%	33.2%	7.1
11/30/2021	77,953	12,901	4,176	29,212	5.4%	16.6%	32.4%	7.0
12/31/2021	77,996	13,073	3,989	28,538	5.1%	16.8%	30.5%	7.2

Average Participation % by Month	4.9%
Average Participation % for the Period***	10.4%

Top 15 Utilized Fitness Centers

Fitness Center	City	State	Visits	Participants
Lakeshore Foundation	Birmingham	AL	9,886	262
Opelika Sportsplex And Aquatic Center, Opelika Par	Opelika	AL	8,949	242
Faucett Brothers Activity Center	Northport	AL	5,853	219
Keller Wellcare Center	Sheffield	AL	5,630	131
Ymca Of Birmingham - Trussville Branch	Trussville	AL	4,960	130
Thomas Health & Fitness	Fairhope	AL	4,852	155
Providence Hospital Rehabilitation & Wellness Cent	Mobile	AL	4,601	176
Snap Fitness - Talladega	Talladega	AL	4,592	80
Tuscaloosa Ymca	Tuscaloosa	AL	4,424	155
Ymca Of Birmingham - Greystone Family Branch	Birmingham	AL	4,202	137
Athens-Limestone Hospital Wellness Center	Athens	AL	3,949	100
Max Fitness	Auburn	AL	3,939	99
Therapy Plus Fitness Of Mmc - South	Boaz	AL	3,912	91
Huntsville Hospital Wellness Center - Jones Valley	Huntsville	AL	3,674	102
Via! Arlene F. Mitchell Campus	Mobile	AL	3,662	118

** Represents the number of members enrolled in Silver Sneakers.*

*** Represents the number of members enrolled who are actively participating.*

**** Calculated using the total unique members who participated during the period. This % can be higher than the monthly % if there are many partial-period participants.*

Demographic Insights - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

The Demographic pages provide insight into your group's demographic composition and how the health care plan impacts these members based on their age and gender. Links between member demographics and spend may help indicate how future plan years are going to trend, as well as provide your group insight into areas of focus over the next plan year.

Member Snapshot

The male/female ratio did not change from the prior period (37/63).

The plan's current average age of 74.2 increased less than one year. This is not a significant change and therefore should have no effect on utilization and cost.

The plan's average age of 74.2 is less than one year younger than the peer.

The small age difference should have little impact on any utilization differences between the plan and the peer.

The % of members with claims increased by less than a percentage point from the prior period.

Current Silver Sneakers participation is 10.4%, which is 2.8 percentage points lower than the prior period.

Spend Distribution

It is preferable to see a higher percentage of members with claims, as this is typically a good indicator that members are receiving needed services such as preventive screenings and maintenance medications.

The % of members receiving preventive services increased 5.1 percentage points from the prior period.

The plan's % of members receiving preventive services is 3.2 percentage points higher than the peer.

When compared to the peer, a larger percentage of your members have Preventive Services, Prescriptions, Other Medical Services.

Females 70 - 74 and Females 65 - 69 years of age make up the majority of spend, accounting for 30.3% of the total cost, while representing 35.3% of the membership.

Member Engagement

94.8% of members have a phone number on file, up 0.2 percentage points from the prior period.

It is important to continually encourage your retirees to keep their telephone numbers on file and up-to-date with you and the health plan. Humana relies on these numbers when clinical outreach is necessary.

63.0% of members have an e-mail address on file, increasing 2.4 percentage points over the prior period. Your percentage is higher than the peer's average of 31.7%.

20.1% of members have registered on MyHumana.com, which is a 6.3 point increase since prior period. Your percentage is lower than the peer's average of 38.0%.

Humana's target for MyHumana.com member registration is 30%. You are 10 percentage points away from achieving this target.

Clinical Program Summary - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Humana works to control health care costs by offering programs to help members with serious medical conditions. These online, telephonic, and face-to-face programs help members effectively manage their conditions, better utilize the healthcare system and maximize the value they receive from their benefits.

The Humana Care Management Program provides a member-centric approach to help members establish and achieve their health goals. This approach examines the severity of illness while assessing the member's functional limitations.

Our goal is to help members live their best possible life at home by empowering them with information, resources and encouragement to enable them to better self-manage their health.

Participation by Program
Members may be enrolled in multiple programs

			% Eligible Participating	
Clinical Programs	Total Eligible	Participated During Period	Current	Prior
Care Management	5,757	4,365	75.8%	68.2%
Transplant***	150	150	100.0%	100.0%
Transitions*	1,122	1,122	100.0%	100.0%
Senior Case Management	3,466	2,586	74.6%	75.5%
Medication Therapy Management**	7,301	5,430	74.4%	78.6%
Kidney Care	616	616	100.0%	100.0%

** Transitions is in-home and telephonic post discharge care management.*

*** Medication Therapy Management is available only to groups with Part D.*

****100% of Transplant members are managed by Humana's Transplant Team.*

Members who graduated from active care management, members who are unable to be contacted, or who declined program participation, are all moved to a Monitored level of care. These members are continuously monitored for potential outreach if they trigger for an alert. Clinical triggers allow us to move beyond calendared calls and contact members when they need us the most. These members also have access to their Care Manager at any time, if they feel they need additional support.

Many patients take multiple medications prescribed by more than one prescriber. Having multiple medications and prescribers increases the risks of drug-to-drug interactions and potential side effects. As part of Humana's Medication Therapy Management (MTM) program, eligible patients can have a face-to-face or telephonic consultation with a qualified health care professional. The goal of this program is to optimize therapeutic outcomes by focusing on safety, effectiveness, lower-cost alternatives and adherence.

Tips

Encourage eligible members to participate in the Humana Care Management Program. Participating members experience improved health outcomes, higher plan satisfaction, and live longer in comparison to non-participating members.

Clinical Services for High Cost/Risk - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

The following chart details the total number of program interventions that occurred for your members categorized by:
- High Cost: members with $15,000 or more in claim costs in the period
- At Risk: members whose severity scores indicate a likelihood of high claim costs for the next year
- Members with Admissions: members with inpatient stays in the period

A member may participate in more than one clinical program and may have multiple gaps in care, resulting in many Humana health alerts generated. A member may have multiple reviews performed as part of Utilization Management. These reviews may include medical and behavioral health services that are received in an inpatient or outpatient setting.

Clinical Program Interventions by High Cost and High Risk - Total Touches

	High Cost (>$15,000)	At Risk	Members with Admissions	Total Membership
Member Count	19,991	22,147	8,477	81,364
Clinical Program Outreach	46,834	44,361	29,267	82,293
Humana Health Alerts Generated (Gaps in Care)	94,862	106,565	43,740	270,936
Utilization Management Reviews*	77,590	70,635	42,466	128,832
Total Member Interventions	**219,286**	**221,561**	**115,473**	**482,061**

Clinical Participation by High Cost and High Risk - Unique Members

	High Cost (>$15,000)	At Risk	Members with Admissions	Total Membership
Member Count	19,991	22,147	8,477	81,364
Clinician Outreach:				
Completed Program During Period	2,172	1,402	1,936	3,025
Enrolled at Period End Date	7,074	7,623	3,295	19,574
Engaged Since Period End Date	470	502	193	1,451
Engaged with Clinical Programs:**	9,716	9,527	5,424	24,050
Non-participation				
Non-participation	174	154	137	470
Engagement from prior reporting period:				
Former Participants	1,292	1,619	317	3,798
Previous Outreach: Non-Participant	723	789	128	1,179
Low Opportunity for Impact/Well Managed***	8,086	10,058	2,471	51,867

**Utilization Management review counts began including those for behavioral health services as of 3/1/2014 (Outpatient) and 4/15/2015 (Inpatient)*
***Members enrolled in Personal Nurse Self-Managed are not included.*
****Low Opportunity for Impact /Well Managed includes members who manage their condition appropriately (e.g. members with asthma who control their condition) and certain conditions/procedures that do not present opportunity to impact health or utilization (e.g. appendectomy, knee replacement, certain skin cancers, etc.)*

Health Alerts - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

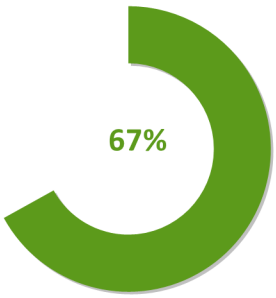
Humana Health Alerts promote better health through evidence-based medicine and preventive care. Each message is tailored to the action needed to close each gap in care and to address the member's situation. The messages encourage members to obtain the care needed for better outcomes, lower costs, and healthier lives.

This chart displays the clinical categories for which health alerts are generated. The alerts are specifically related to the disease or condition listed. **Alert** compliance represents the number of alerts in which members followed recommended care (includes the compliant alerts and those alerts which changed from non-compliant to compliant), therefore requiring no further action by the member.

Disease Category	Alerts Qualified	Alerts Generated	Alerts Closed	% Closed	% Compliant	Peer % Compliant
Total	**844,589**	**270,650**	**109,289**	**40.4%**	**80.9%**	**81.2%**
Cardiovascular	326,117	95,760	42,947	44.8%	83.8%	80.4%
Diabetes	195,697	55,328	25,208	45.6%	84.6%	81.4%
Geriatrics	153,711	24,872	5,649	22.7%	87.5%	88.5%
Prevention and Screening	97,656	52,587	19,819	37.7%	66.4%	78.7%
Musculoskeletal	44,062	24,702	3,963	16.0%	52.9%	41.5%
Respiratory	8,366	6,163	3,992	64.8%	74.1%	65.3%
Auto-Immune Disease	5,623	892	260	29.1%	88.8%	88.2%
Liver	5,138	5,102	4,940	96.8%	96.8%	96.7%
Osteoporosis	3,861	1,842	652	35.4%	69.2%	66.7%
Immune system	3,074	2,753	1,590	57.8%	62.2%	65.1%
Cancer	1,284	649	269	41.4%	70.4%	65.2%

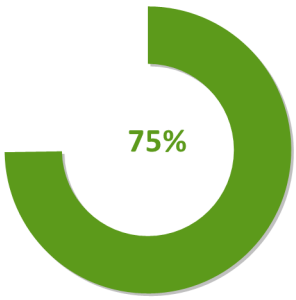
The following charts showcase **Member** compliance rates. Fully Compliant members have no open Humana Health Alerts.

Current Period



Total Members: 62,497

Prior Period



Total Members: 57,092

Tips

Members who obtain all needed medical procedures and are compliant with their prescribed medications are more likely to have better health outcomes and lower health costs over time. Humana has a variety of member outreach programs which encourage members to get more involved in their healthcare and to control their health costs.

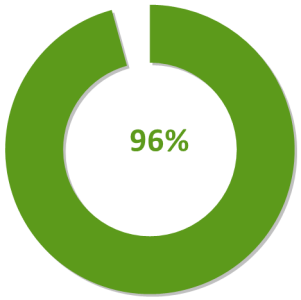
Preventive Services - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Good health begins with prevention. The current regulatory environment and the healthcare systems concur with this position, providing preventive services at no direct cost to the member. Many diseases are far more treatable and less costly when found in the early stages of development. With this in mind, Humana educates our members about the importance of getting their recommended preventive services.

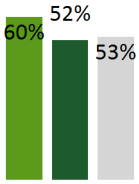
Members Receiving at least one Preventive Service

	Current	Prior	Peer
Total Membership	76.1%	71.0%	72.9%
Female	80.4%	75.7%	78.6%
Male	68.6%	63.1%	64.9%
Large Claimants	71.3%	65.5%	---

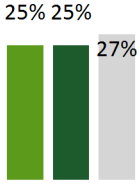
Member Compliance of Preventive Health Alerts



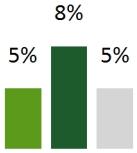
Preventive Office Visits



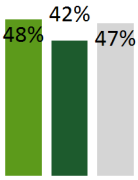
Influenza Vaccinations



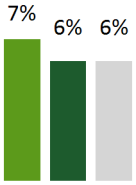
Pneumococcal Immunizations



Breast Cancer Screenings



Colorectal Cancer Screenings



Percentages based on target population of 77,996 members

Current | Prior | National Peer

Tips

Prevention is an important step to better health. These preventive services can lead to early identification of illnesses which will help lower the physical, emotional and financial burden on your retirees.

Wellness Insights - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Health screenings help to keep your members happy and healthy resulting in lower healthcare spending. Humana's wellness tools provide members the opportunity to get healthier. Consequently, throughout the Wellness section we strive for very high participation since this part of the benefit plan results in improved member health. We encourage groups to promote, educate, and reward members heavily through wellness as the rewards for the company will be gained for many years to come.

Clinical Services

Of the 81,364 members reviewed during this period, Humana outreached to 24,520 (30.1%) and 24,050 (29.6%) engaged with a program.

Humana focuses on members with high costs and members who are at risk for high costs. 19,991 members were identified as high cost (>$15K in spend). 9,890 (49%) were outreached for a program, and 9,716 (49%) participated.

In the At Risk category, 22,147 were identified and 9,681 (44%) were outreached for a clinical program and 9,527 (43%) were engaged.

Of the 8,477 members with admissions, 5,561 (66%) were outreached and 5,424 (64%) engaged with a program.

Driving program participation is critical to improving the health of members and lowering cost. Recommendations include continued communication of the Humana Clinical Programs, and encouraging accurate email and phone numbers are on file in order to promote timely and achievable outreach.

Health Alerts

Health alerts aim to improve member health overall by encouraging preventive services, alerting physicians of potential drug interactions, and identifying options that could reduce the risk of complications. These gaps in care may be preventive in nature, disease specific, or related to care modification.

Of the top 3 disease categories for which health alerts are generated, Geriatrics alerts had the highest compliance rate at 87%.

62,497 members had a health alert generated. Of those members, 67.0% were fully compliant, meaning they had no open health alerts by the end of the reporting period.

Fully compliant members decreased 7.8 percentage points from 74.8% to 67.0%.

Messaging examples include notifying the member's provider, flagging gaps in our customer care portal or the member profile for our clinicians, and sending emails or letters (when appropriate) to the member. Messages can come via a member's SmartSummary statement, in an email, a phone call, in the mail, or sent to a primary care physician.

These messages provide actionable, relevant information that can improve members' health and awareness, and empower them to take charge of their own well-being.

Preventive

76% of members received a preventive service during the current reporting period.

The plan's preventive service rate increased by 5.1 percentage points from the prior period. Continue to promote the benefits of preventive services.

Out of the 76% of members who received a preventive service, 96% of members with generated health alerts were fully compliant.

The plan's current preventive service rates are higher than the prior period in the following categories: Preventive Office Visits, Breast Cancer Screenings, Colorectal Cancer Screenings

The plan's preventive service rates are lower than the peer in the following categories: Influenza Vaccinations.

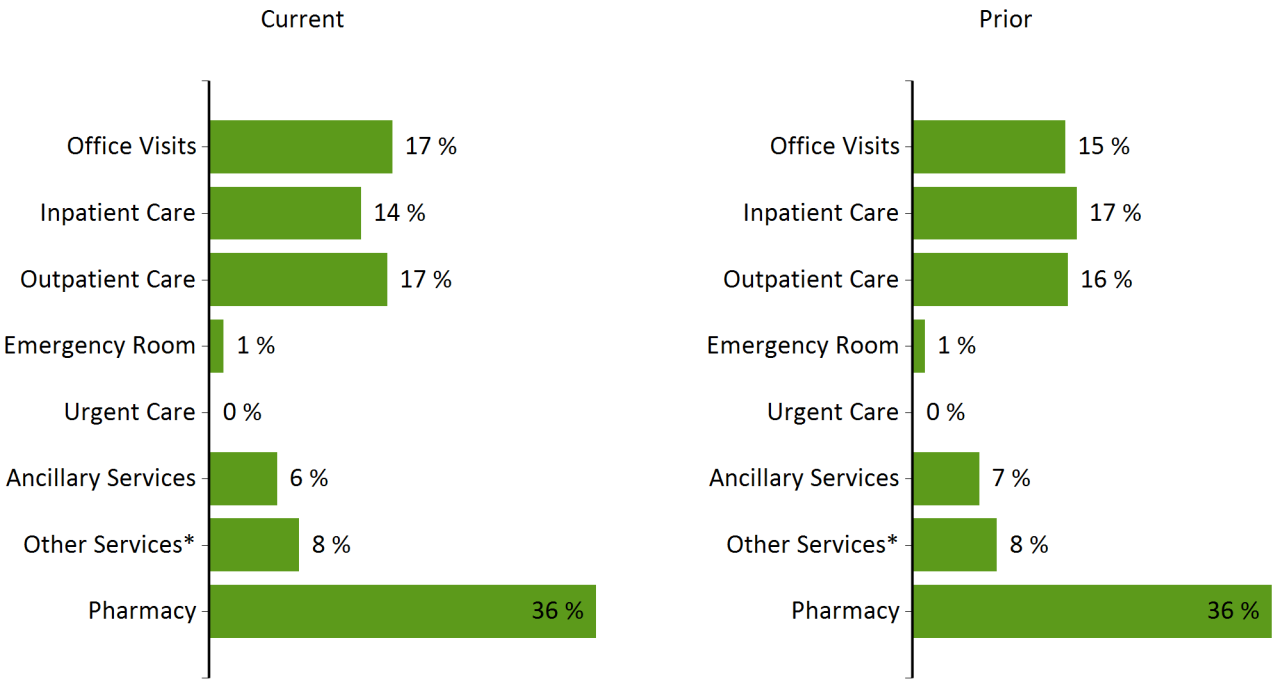
Large claimants are receiving preventive services at a lower rate than the total membership.

Plan Spend Snapshot - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Several factors must be considered to understand your group's spend. The average cost of a service, the member's contribution, and the rate of utilization can heavily influence the numbers. Other influences to consider include the impact of large claimant spend, your demographic composition, how engaged your members are with taking responsibility for their health, and how knowledgeable your members are about their benefits.

	Net Paid PMPM		% Change
	Current	Prior	
Medical	$862.11	$808.58	6.6%
Pharmacy	$458.33	$424.91	7.9%
Grand Total	$1,320.44	$1,233.49	7.0%

Spend Distribution by Place of Treatment



**Other services includes paid amounts for facility based physicians, freestanding labs, skilled nursing facilities, inpatient rehabilitation facilities, and inpatient/outpatient physician services.*

Utilization Scorecard - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

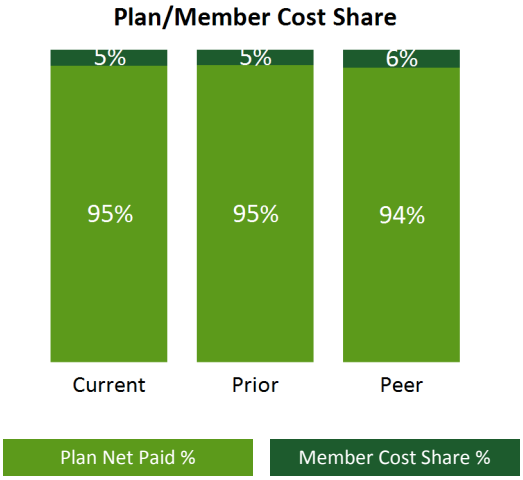
Monitoring utilization allows your group to be aware of adverse trend and cost situations on their plan. It is typically a positive situation to see Primary Care Provider utilization increasing. Additionally, we often encourage greater use of ambulatory surgical centers and urgent care facilities, when the severity of the conditions warrants.

	Group Utilization		% Change	Peer	% In-Network
	Current	Prior		Current	Current
Office Visits					88%
Primary Care Visits per 1,000	4,288	3,960	8.3%	3,954	
Specialist Care Visits per 1,000	10,175	8,675	17.3%	8,255	
Inpatient Care					92%
Acute Hospital Admits per 1,000	140	162	-13.3%	160	
Acute Hospital Days per 1,000	977	1,028	-4.9%	993	
Case Mix Index	2.17	2.12	2.4%	---	
Long Term Acute Care Admits per 1,000	0.48	0.52	-8.6%	0.45	
Outpatient Care					85%
Ambulatory Surgical Center Visits per 1,000	150	124	21.4%	112	
Other Outpatient Procedures per 1,000	3,930	3,643	7.9%	5,010	
Outpatient Hospital Surgeries per 1,000	409	349	17.3%	423	
Emergency Room					92%
Visits per 1,000	250	222	12.8%	277	
% of Repeat ER Visits	8%	8%	0.7%	---	
% of Inappropriate ER Visits	8%	10%	-1.2%	---	
Urgent Care					74%
Visits per 1,000	157	161	-2.2%	230	
Urgent Care to ER	4	3	3.3%	---	
Ancilllary Services					73%
Ancillary Visits per 1,000	4,747	4,600	3.2%	4,649	
Other Services*	8,611	8,055	6.9%	8,832	
Pharmacy					
Prescriptions per 1,000	36,797	37,192	-1.1%	30,094	

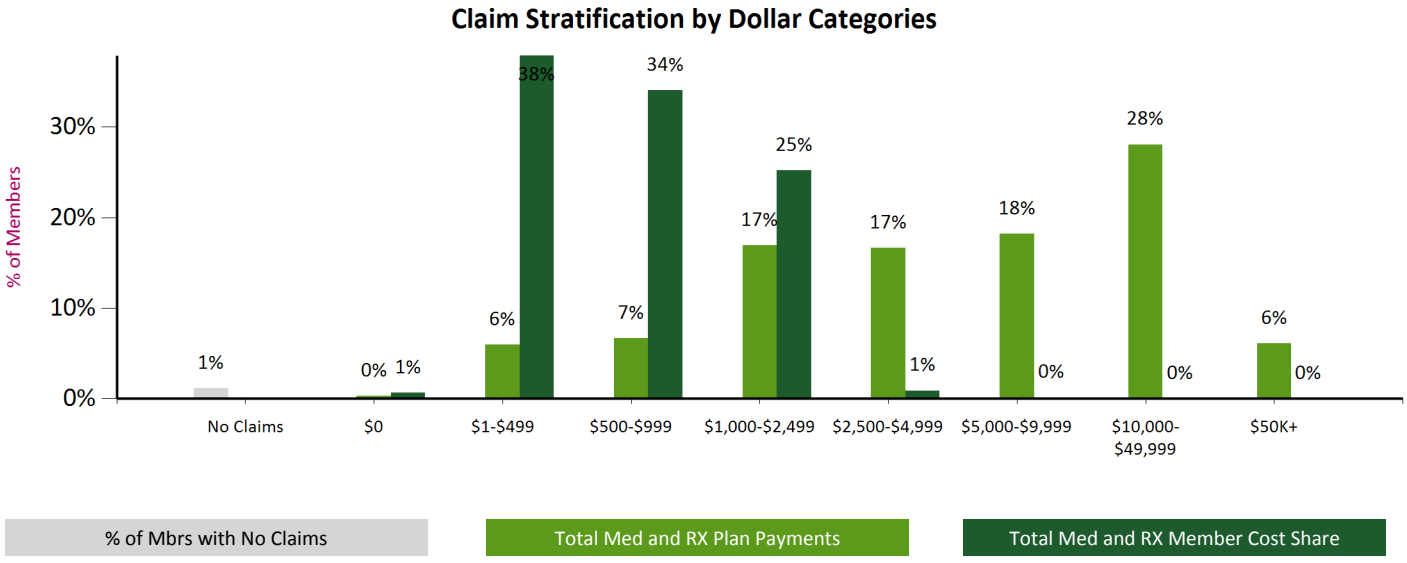
*Other services includes paid amounts for facility based physicians, freestanding labs, skilled nursing facilities, inpatient rehabilitation facilities, and inpatient/outpatient physician services.

Cost Share and Stratification - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Knowing your plan and member cost share will help determine when either the plan or the member may be bearing an unusually high percentage of the cost. Use this information to understand if changes to benefit design resulted in a cost share shift or if changes may be needed in the future.



	Current	Prior	% Change
Plan Paid PMPM	$1,320.44	$1,233.49	7.0%
Member Paid PMPM	$67.18	$61.69	8.9%



Prevalence Summary - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Prevalence, or the unique number of members diagnosed with a condition, identifies the conditions for which your members are seeking treatment, and the degree to which conditions are common in your group's population. Abnormally high prevalence, as compared to the peer, may be an indication of a present or future concern for a customer, especially for conditions that often require expensive treatments.

Top 10 Medical Conditions - by Prevalence

Current Rank	Prior Rank	Medical Condition	Active Members Diagnosed	Prevalence %	12-Month Peer	Medical % of Spend	
						Current	Prior
1	1	SUPPLEMENTARY CLASSIFICATION OF FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES	77,288	100.2%	92.6%	9.5%	8.8%
2	2	ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	70,885	91.9%	83.9%	4.1%	3.6%
3	4	SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS, NOT ELSEWHERE CLASSIFIED	68,267	88.5%	79.4%	5.9%	5.6%
4	3	DISEASES OF THE CIRCULATORY SYSTEM	67,586	87.6%	79.1%	15.5%	15.2%
5	5	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE	61,125	79.2%	69.9%	12.9%	11.8%
6	6	DISEASES OF THE GENITOURINARY SYSTEM	45,289	58.7%	49.9%	5.8%	6.1%
7	8	DISEASES OF THE EYE AND ADNEXA	44,913	58.2%	50.5%	3.5%	3.0%
8	7	DISEASES OF THE DIGESTIVE SYSTEM	43,821	56.8%	47.3%	4.2%	4.0%
9	11	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE	39,255	50.9%	45.6%	1.7%	1.8%
10	9	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	39,115	50.7%	44.8%	3.8%	3.8%
						67.0%	63.8%

Top 3 Medical Conditions - by Spend

#1 DISEASES OF THE CIRCULATORY SYSTEM

	Current	Prior	Change
# of Members Diagnosed	67,586	65,596	
Medical % of Spend	15.5%	15.2%	0.3%
Large Claimant Impact on Spend %	2.6%	2.5%	0.1%

#2 DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

	Current	Prior	Change
# of Members Diagnosed	61,125	58,513	
Medical % of Spend	12.9%	11.8%	1.1%
Large Claimant Impact on Spend %	1.5%	1.2%	0.3%

#3 NEOPLASMS

	Current	Prior	Change
# of Members Diagnosed	34,450	31,082	
Medical % of Spend	9.6%	9.5%	0.1%
Large Claimant Impact on Spend %	5.9%	6.2%	-0.3%

Tips

While all conditions warrant attention, heightened concern may be appropriate when a high prevalence of Diabetes, Cancer, or heart-related ailments are present. Additionally, highly acute conditions such as Injury, motor vehicle accidents, etc., may be heavily impacting current plan costs.

Contact your Humana Representative to learn about Humana Clinical Programs and Go365. These programs will help educate and encourage your members to get the correct treatment at the best place of treatment possible.

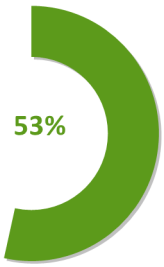
Large Claimant Impact - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Large variations in total plan cost and high plan spend is often a result of increasing or excessive Large Claimants. Humana typically expects overall spend for Large Claimants (in excess of $100k) to be in the 15%-20% range. However, some plans experience spend for Large Claimants that is much higher than this expected level as a result of either one or some very high cost Large Claimants ($200k or higher cost), or a higher number of Large Claimants than would be expected. In either case, your group can expect Humana's utilization management efforts to keep these costs as low as possible. Often, Large Claimants are being managed by Case Management, as well as receiving services from Humana's Clinical Programs. In this way, the appropriate type and level of care will be provided to the member involved.

Large Claimant Impact

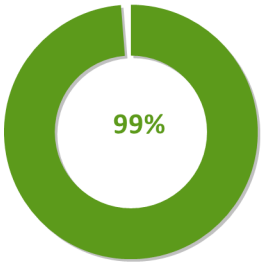
Dollar Threshold	# of Claimants		Med/RX Split	% of Spend		% of Spend - Peer	
	Current	Prior	Current	Current	Prior	Current	Prior
>$50,000	4,977	4,571	59/41	42.8%	43.0%	36.9%	35.6%
>$75,000	2,715	2,540	54/46	31.1%	31.5%	23.9%	23.0%
>$100,000	**1,567**	**1,467**	**51/49**	**22.7%**	**22.9%**	**16.1%**	**15.3%**

Health Alert Compliance %



Health Alert Compliance represents the % of Large Claimants who are fully compliant with no gaps in care.

Clinical Program Participation %



Clinical Program Participation represents the % of Large Claimants who participated in a clinical program during the reporting period.

Top Ten Large Claimants >$100,000

	Medical Condition	Clinical Program Status	Status
#1	DISEASES OF THE RESPIRATORY SYSTEM	Currently Enrolled	Active
#2	SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS, NOT ELSEWHERE CLASSIFIED	Currently Enrolled	Active
#3	DISEASES OF THE RESPIRATORY SYSTEM	Low Opportunity for Impact	Termed
#4	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE	Former Participant	Active
#5	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	Previous Outreach Non-Participant	Active
#6	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	Currently Enrolled	Active
#7	ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	Low Opportunity for Impact	Active
#8	CODES FOR SPECIAL PURPOSES	Currently Enrolled	Active
#9	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	Currently Enrolled	Active
#10	ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	Former Participant	Active

Impact of Top 10 Large Claimants	% of Total Spend
	0.7%

Spend and Utilization Insights - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Understanding utilization trends, and the associated costs, give your group the opportunity to recognize member behavior patterns with the most financial impact. This information will help you make plan changes that encourage members to seek care at the appropriate place of treatment. Specifically, this can be accomplished by analyzing the following areas: Prevalence, Place of Treatment, Utilization Rates, Cost Share and Large Claimants.

Plan Spend & Utilization

Overall plan spend increased by 7.0%. Medical spend increased by 6.6% and pharmacy spend increased by 7.9%.

The top three spend drivers by place of treatment are: Office Visits followed by Outpatient Care then Inpatient Care.

The following three Places of Treatment had the most significant increases in utilization: Office Visits followed by Emergency Room and then Outpatient Care.

A relationship with a PCP is critical to managing member health. PCP utilization increased from the prior year by 8.3%.

Cost Share & Stratification

Plan/Member Cost share is 95/5.

The plan's cost share decreased less than a percentage point from the prior period.

Plan cost share is less than a percentage point higher than the peer.

The percentage of members that spent less than $1,000 out-of-pocket is 74%. 25% spent $1,000 - $2,499 and 1% spent greater than $2,499 out-of-pocket.

1% of members had no claims during the reporting period.

Clinical Condition Spend & Prevalence

The plan's top 10 most prevalent clinical conditions account for 67% of your medical spend and 44% of your total spend.

The most costly clinical condition was DISEASES OF THE CIRCULATORY SYSTEM, which represents 10% of your total spend.

The top 3 most expensive clinical conditions account for 38% of your medical spend.

Large Claimants are present in each of the top 3 categories.

Large Claimant Impact

The number of Large Claimants ($100k) on the plan increased from 1,467 to 1,567 members.

Large Claimants account for 22.7% of the spend this year which is down less than a percentage point from last year.

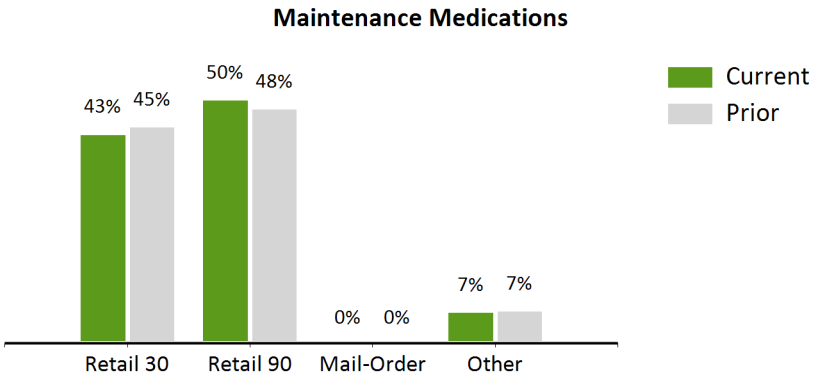
The plan's large claimant health alert full compliance rate is lower than it is for your entire population.

The plan's top 10 large claimants account for 0.7% of your total spend.

Pharmacy Snapshot - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Drug costs have continued to outpace the cost of all other health care components by a significant margin. Understanding your pharmacy utilization and cost drivers will empower you to optimize your members' pharmacy benefits and contain costs.

Pharmacy Utilization Summary	Current	Prior	Change	Current Peer	Prior Peer	Change Peer
Average # of Members	77,149	76,235	1.2%	---	---	---
% Utilizing Members per Month	79.6%	79.4%	0.2%	---	---	---
Total # of Prescriptions	2,838,867	2,835,325	0.1%	---	---	---
Total Prescriptions PMPM	3.07	3.10	-1.1%	2.68	2.84	-5.5%
Days Supply PMPM	153.06	152.10	0.6%	145.11	153.62	-5.5%
Net Paid/Script*	$89.83	$83.81	7.2%	$83.32	$76.78	8.5%
Net Paid PMPM	$458.33	$424.91	7.9%	$403.02	$393.16	2.5%
Member Paid PMPM	$35.47	$35.17	0.9%	$33.41	$33.26	0.5%
Plan Cost Share	92.8%	92.4%	0.5%	---	---	---



Tips

Maintenance Medications are drugs that the member takes regularly to treat ongoing conditions. Mail-order is a convenient way for members to have these meds delivered to their door.

Maintenance drug adherence is found to be higher for members who use mail order delivery, since prescriptions are delivered directly to the member's home.

**Other = Specialty, Long Term Care, Home Infusion, and Discount Card Prescriptions*

Specialty Drug Usage	Current	Prior	Change	Current Peer	Prior Peer	Change Peer
Total # of RX	34,520	31,663	9.0%	---	---	---
Average Plan Net Paid per RX*	$5,318	$5,426	-2.0%	$5,130	$5,049	1.6%
Average Member Net Paid per RX*	$42	$43	-2.1%	$79	$89	-11.6%
Specialty Net Paid PMPM	$215.26	$194.61	10.6%	$158.21	$142.75	10.8%

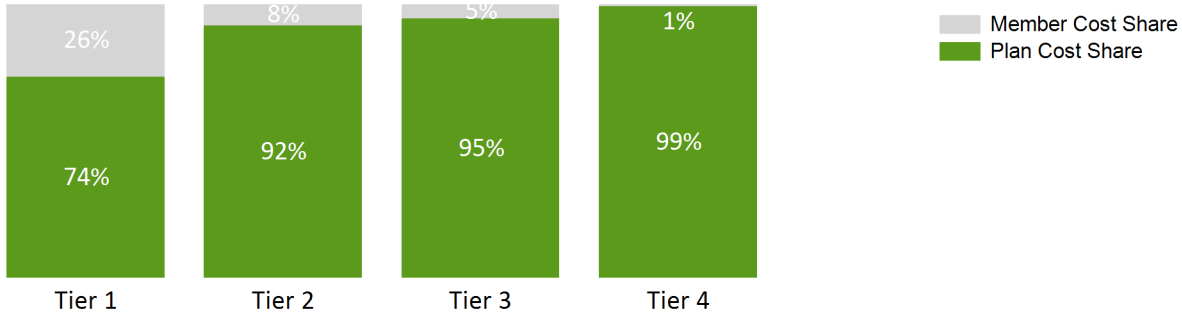
Generics Usage	Current	Prior	Change	Current Peer	Prior Peer	Change Peer
Generic Dispensing Rate	85.7%	85.3%	0.4%	85.5%	85.4%	0.1%
Total # of RX	2,433,200	2,419,534	0.6%	---	---	---
Average Plan Net Paid per RX*	$11	$12	-11.7%	$9	$10	-10.6%
Average Member Cost per RX*	$4	$4	-2.9%	$4	$4	3.9%
Generic Net Paid PMPM	$48.81	$54.89	-11.1%	$37.67	$44.59	-15.5%

**30-day equivalent*

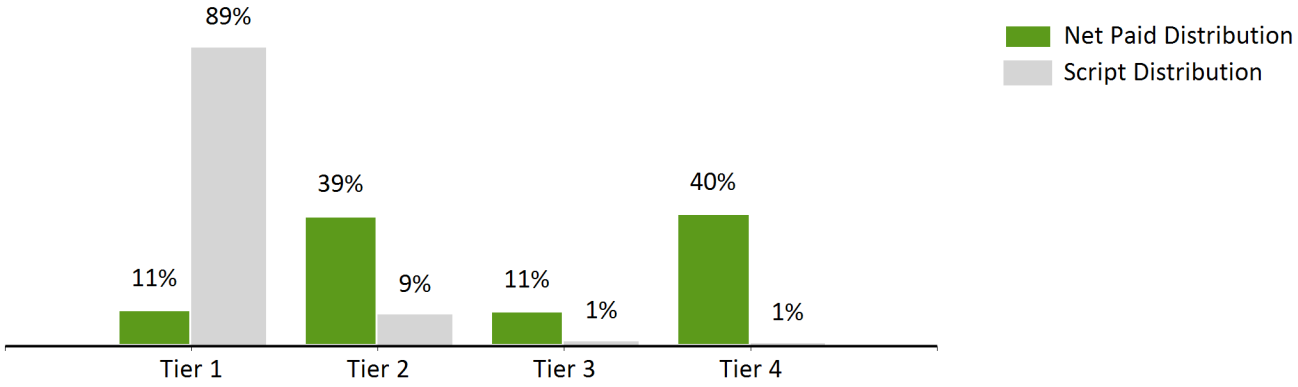
Tier Distribution - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

The Tier Distribution page displays several of Humana's key pharmacy metrics for each tier related to plan cost, member cost share and script duration. It can be clearly seen in the graphs and tables below that as you progress through the tiers, plan cost share increases while member cost share decreases significantly. Keeping a member on low cost, low tier generic and brand drugs when effectively treating the member's condition is a win-win scenario for the plan and the member. Specialty and high cost biologics are typically found in the highest drug tier.

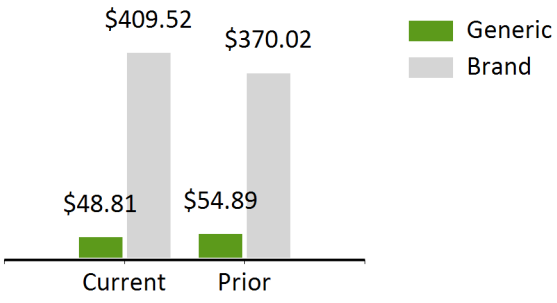
Cost Share Distribution by Tier



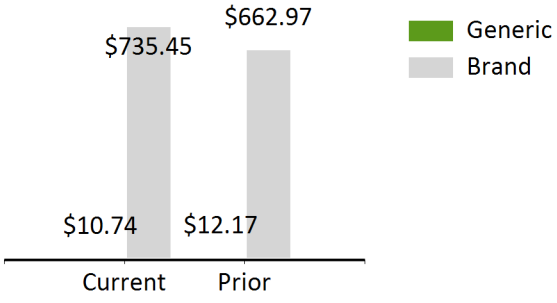
Prescription and Plan Paid Distribution by Tier



Generic vs. Brand Net Paid PMPM



Generic vs. Brand Net Paid / Script*



*30-day equivalent

Tips

Members can use the Drug List Search Tool at MyHumana.com to see if a generic alternative is available.

Specialty Drugs - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Specialty drugs have no generic or multisource brand alternative. Typically very high in cost, they almost always represent a very small percentage of the overall scripts (less than 2%), but often have costs that exceed 25% or more of overall pharmacy plan spend. These drugs may be prescribed for rare diseases, as well as newer forms of biologic treatment. Heightened levels of attention for specialty drugs are often warranted due to their significant impact on pharmacy costs.

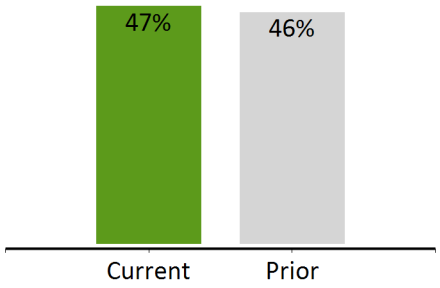
Top 10 Specialty Drugs

Brand Name	Drug Class	Net Paid	Scripts
HUMIRA PEN	RHEUMATOID ARTHRITIS	$14,557,412	2,149
REVLIMID	CHEMOTHERAPY - MULTIPLE MYELOMA AGE	$14,312,693	856
IMBRUVICA	CHEMOTHERAPY	$7,702,725	572
COSENTYX SENSOREADY PEN	DERMATOLOGY - PSORIASIS AGENTS	$5,639,566	826
ENBREL SURECLICK	RHEUMATOID ARTHRITIS	$5,381,275	835
XTANDI	CHEMOTHERAPY - ANTIANDROGENS	$5,288,188	435
POMALYST	CHEMOTHERAPY - MULTIPLE MYELOMA AGE	$5,163,219	261
IBRANCE	CHEMOTHERAPY - CDK INHIBITORS	$4,369,471	322
OFEV	RESPIRATORY - IPF AGENTS	$4,071,072	355
DUPIXENT	DERMATOLOGY	$3,222,395	968

Top 5 Pharmacies for Specialty Drugs

Pharmacy	Utilization
CENTERWELL PHARMACY INC.	15.6%
KIRKLIN CLINIC PHARMACY	6.1%
US BIOSERVICES	3.5%
KROGER SPECIALTY PHARMACY LA	2.8%
STAR DISCOUNT PHARMACY	2.2%

Specialty % of RX Net Paid



Top 25 Drugs by Cost - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Current Rank	Prior Rank	Drug Name	Generic / Brand	Drug Class	Tier	# of RX	Avg Day Supply	Plan Paid	Avg Plan Paid / RX	% Paid
1	1	Eliquis	B	Cardiology - Blood Thinners	2	40,540	41.0	$26,959,686	$665	6.4%
2	3	Humira Pen	B	Rheumatoid Arthritis	4	2,149	28.1	$14,557,412	$6,774	3.4%
3	2	Revlimid	B	Chemotherapy - Multiple Myelo	4	856	27.2	$14,312,693	$16,720	3.4%
4	4	Trulicity	B	Diabetes	2	12,585	33.9	$12,794,832	$1,017	3.0%
5	5	Januvia	B	Diabetes	2	10,709	48.6	$8,450,196	$789	2.0%
6	6	Xarelto	B	Cardiology - Blood Thinners	2	11,638	44.7	$8,351,537	$718	2.0%
7	16	Ozempic	B	Diabetes	2	7,870	34.5	$7,929,527	$1,008	1.9%
8	7	Imbruvica	B	Chemotherapy	4	572	28.5	$7,702,725	$13,466	1.8%
9	12	Jardiance	B	Diabetes	2	8,598	45.4	$7,049,464	$820	1.7%
10	8	Lantus Solostar	B	Diabetes	2	11,020	48.2	$6,619,184	$601	1.6%
11	10	Myrbetriq	B	Genitourinary	2	11,826	38.0	$6,074,522	$514	1.4%
12	13	Cosentyx Sensoready Pen	B	Dermatology - Psoriasis Agent	4	826	28.0	$5,639,566	$6,828	1.3%
13	14	Enbrel Sureclick	B	Rheumatoid Arthritis	4	835	28.1	$5,381,275	$6,445	1.3%
14	9	Xtandi	B	Chemotherapy - Antiandrogens	4	435	29.9	$5,288,188	$12,157	1.3%
15	15	Pomalyst	B	Chemotherapy - Multiple Myelo	4	261	27.7	$5,163,219	$19,782	1.2%
16	17	Ibrance	B	Chemotherapy - Cdk Inhibitors	4	322	27.9	$4,369,471	$13,570	1.0%
17	11	Victoza	B	Diabetes	2	3,439	41.0	$4,367,272	$1,270	1.0%
18	28	Ofev	B	Respiratory - Ipf Agents	4	355	30.0	$4,071,072	$11,468	1.0%
19	27	Entresto	B	Cardiology - Heart Failure	2	4,951	39.5	$3,601,204	$727	0.9%
20	22	Restasis	B	Ophthalmology	2	4,409	39.0	$3,436,617	$779	0.8%
21	47	Dupixent	B	Dermatology	4	968	27.6	$3,222,395	$3,329	0.8%
22	20	Jakafi	B	Chemotherapy	4	203	29.9	$3,168,560	$15,609	0.8%
23	52	Rinvoq	B	Rheumatoid Arthritis	4	562	30.0	$3,090,540	$5,499	0.7%
24	19	Breo Ellipta	B	Respiratory - Copd	2	7,577	34.0	$3,055,857	$403	0.7%
25	18	Humalog Kwikpen	B	Diabetes	2	3,313	44.8	$3,037,699	$917	0.7%
Total of Top 25 Drugs by Plan Cost						146,819	40.3	$177,694,714	$1,210	41.9%

Top 25 Drugs by Quantity - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Current Rank	Prior Rank	Drug Name	Generic / Brand	Drug Class	Tier	# of RX	Avg Day Supply	Plan Paid	Avg Plan Paid / RX	% Paid
1	1	Atorvastatin Calcium	G	Cholesterol	1	75,554	77.5	$152,926	$2	0.0%
2	3	Amlodipine Besylate	G	Cardiology - Hypertension Age	1	67,812	74.7	$18,637	$0	0.0%
3	2	Levothyroxine Sodium	G	Thyroid	1	66,566	72.2	$920,335	$14	0.2%
4	4	Losartan Potassium	G	Cardiology - Hypertension Age	1	49,864	76.7	$234,250	$5	0.1%
5	5	Gabapentin	G	Anticonvulsants	1	47,365	44.3	$182,114	$4	0.0%
6	6	Pantoprazole Sodium	G	Gastrointestinal Disease - Ge	1	44,668	67.1	$63,473	$1	0.0%
7	8	Metoprolol Succinate Er	G	Cardiology - Hypertension Age	1	41,640	74.4	$548,636	$13	0.1%
8	10	Eliquis	B	Cardiology - Blood Thinners	2	40,540	41.0	$26,959,686	$665	6.4%
9	7	Lisinopril	G	Cardiology - Hypertension Age	1	39,791	76.8	$11,884	$0	0.0%
10	9	Omeprazole	G	Gastrointestinal Disease - Ge	1	38,933	69.2	$31,920	$1	0.0%
11	14	Rosuvastatin Calcium	G	Cholesterol	1	36,045	79.1	$49,002	$1	0.0%
12	12	Vitamin D	G	Nutritional/ Vitamin	1	35,754	28.2	$8,240	$0	0.0%
13	11	Hydrochlorothiazide	G	Cardiology - Hypertension Age	1	32,266	76.8	$11,629	$0	0.0%
14	13	Simvastatin	G	Cholesterol	1	31,113	80.0	$7,874	$0	0.0%
15	20	Hydrocodone Bitartrate/Acetaminophen	G	Pain Mgmt - Narcotic Analgesi	1	30,264	19.0	$207,012	$7	0.1%
16	15	Furosemide	G	Cardiology - Hypertension Age	1	30,086	60.5	$24,982	$1	0.0%
17	19	Meloxicam	G	Pain Mgmt - Nsaid Agents	1	29,908	55.2	$6,275	$0	0.0%
18	16	Carvedilol	G	Cardiology - Hypertension Age	1	29,882	71.7	$20,038	$1	0.0%
19	18	Metformin Hydrochloride	G	Diabetes	1	29,568	75.4	$10,739	$0	0.0%
20	17	Potassium Chloride Er	G	Nutritional/ Vitamin	1	28,478	61.6	$491,259	$17	0.1%
21	21	Tramadol Hcl	G	Pain Mgmt - Narcotic Analgesi	1	27,156	20.8	$43,177	$2	0.0%
22	22	Montelukast Sodium	G	Respiratory - Asthma	1	27,132	68.4	$40,049	$1	0.0%
23	25	Tamsulosin Hydrochloride	G	Genitourinary	1	26,573	70.5	$70,064	$3	0.0%
24	23	Pravastatin Sodium	G	Cholesterol	1	26,363	79.4	$292,940	$11	0.1%
25	27	Trazodone Hydrochloride	G	Mental Health - Depression Ag	1	24,483	55.8	$65,315	$3	0.0%
Total of Top 25 Drugs by Quantity						957,804	64.6	$30,472,456	$32	7.2%

Pharmacy Insights - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Humana's pharmacy program offers a wide variety of high quality, effective generic and brand-name drugs. We believe that paying attention to your specialty medications and tier distribution on the plan will help control spend, allowing members to utilize their prescription benefit in the most effective manner. Educating members on the benefits of using Humana's mail-order pharmacy, especially for maintenance drugs, as well as using generics when available, will result in lower costs for the group as well as the member.

Pharmacy Snapshot

The plan experienced a 1.2% increase in membership and subsequently had a 0.1% increase in total prescriptions.

The number of prescriptions filled per member per month decreased by 1.1% from the prior period.

The number of prescriptions filled per member per month of 3.07 is higher than the peer of 2.68

Your members are paying $35.47 per member per month, which is a 0.9% increase from prior period.

The plan paid $458.33 per member per month, which is a 7.9% increase from prior period and is also 92.8% of the total drug expense.

On average, your members pay more for their prescriptions when compared to the peer.

Your generic dispensing rate increased 0.4% from the prior period and is 0.3% higher than the peer.

Tier Distribution

Drug costs increase markedly as you move up through the tiers. Fortunately, most scripts come from the lower tiers. 97.9% of scripts are in Tiers 1 and 2.

The per prescription cost spread between what the plan pays and what the member pays increases significantly as you move up in tiers.

The plan paid an average of $10.74 per generic prescription, compared to an average of $735.45 per brand prescription.

While brand drugs account for only 14% of prescriptions, they comprise 89% of your total pharmacy cost.

Specialty

The number of specialty drug prescriptions increased 9%, and the average plan paid per specialty prescription decreased 2%.

Your average paid per specialty script is $188 more than the peer of $5,130.

Members are paying less per specialty prescription, down 2% from $43 to $42.

None of your specialty drug prescriptions were filled through Humana Pharmacy. With the introduction of new drugs in the pipelines, the area of specialty pharmacy spend is expected to continue to grow in the future.

Utilization management as well as oversight on dispensing these medications will become more important in the future. Humana Pharmacy has unique Utilization Management techniques in place to help members on specialty medications.

Conclusions - SAMPLE
Reporting Period: 01/01/2021 - 12/31/2021

Demographics

The male/female ratio did not change from the prior period (37/63).

The plan's current average age of 74.2 increased less than one year. This is not a significant change and therefore should have no effect on utilization and cost.

Current Silver Sneakers participation is 10.4%, which is 2.8 percentage points lower than the prior period.

The plan's % of members receiving preventive services is 3.2 percentage points higher than the peer.

Females 70 - 74 and Females 65 - 69 years of age make up the majority of spend, accounting for 30.3% of the total cost, while representing 35.3% of the membership.

94.8% of members have a phone number on file, up 0.2 percentage points from the prior period.

Humana's target for MyHumana.com member registration is 30%. You are 10 percentage points away from achieving this target.

Wellness

Humana identified 61,125 members with a claim for Musculoskeletal and generated 404,964 total member interventions (includes clinical program outreach, Humana health alerts generated, and utilization management reviews).

In addition, Humana outreached to 20,366 (33%) of the members with these conditions and 19,978 (33%) members engaged.

62,497 members had a health alert generated. Of those members, 67.0% were fully compliant, meaning they had no open health alerts by the end of the reporting period.

76% of members received a preventive service during the current reporting period.

Out of the 76% of members who received a preventive service, 96% of members with generated health alerts were fully compliant.

Spend & Utilization

Overall plan spend increased by 7.0%. Medical spend increased by 6.6% and pharmacy spend increased by 7.9%.

The top three spend drivers by place of treatment are: Office Visits followed by Outpatient Care then Inpatient Care.

Plan/Member Cost share is 95/5.

The most prevalent major clinical condition was SUPPLEMENTARY CLASSIFICATION OF FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES.

The plan's top 10 most prevalent clinical conditions account for 67% of your medical spend, 0% of your pharmacy spend, and 44% of your total spend.

The most costly clinical condition was DISEASES OF THE CIRCULATORY SYSTEM, which represents 10% of your total spend.

The number of Large Claimants ($100k) on the plan increased from 1,467 to 1,567 members.

Large Claimants account for 22.7% of the spend this year which is down less than a percentage point from last year.

Pharmacy

The plan experienced a 1.2% increase in membership and subsequently had a 0.1% increase in total prescriptions.

The number of prescriptions filled per member per month decreased by 1.1% from the prior period.

The plan paid $458.33 per member per month, which is a 7.9% increase from prior period and is also 92.8% of the total drug expense.

On average, your members pay more for their prescriptions when compared to the peer.

Drug costs increase markedly as you move up through the tiers. Fortunately, most scripts come from the lower tiers. 97.9% of scripts are in Tiers 1 and 2.

The number of specialty drug prescriptions increased 9%, and the average plan paid per specialty prescription decreased 2%.

Your average paid per specialty script is $213 more than the peer of $5,105.

In order of appearance in PlanCompass

Net Paid PMPM % Change

GREEN = % Change is negative
YELLOW = % Change is between 0% and 5.49%
RED = % Change is 5.5% or higher

Medical Admits per 1,000 % Change

GREEN = % Change is negative
YELLOW = % Change is between 0% and 3.99%
RED = % Change is 4% or higher

Prescriptions PMPM Change

GREEN = % Change is negative
YELLOW = % Change is between 0% and 2.99%
RED = % Change is 3% or higher

Specialty % of RX Net Paid % Change

GREEN = % Change is less than -3%
YELLOW = % Change is between -2.99% and 2.99%
RED = % Change is equal to or greater than 3%

Member Cost Share % Change

GREEN = % Change is greater than or equal to 3%
YELLOW = % Change is between -2.99% and 2.99%
RED = % Change is less than -3%

Large Claimant Spend Impact % Change

GREEN = % Change is equal to or less than 0%
YELLOW = Not used
RED = % Change is greater than 0%

Health Alerts Full Compliance % Change

GREEN = % Change is greater than 0%
YELLOW = Not used
RED = % Change is equal to or less than 0%

Members with Preventive Services % Change

GREEN = % Change is equal to or greater than 0%
YELLOW = Not used
RED = % Change is less than 0%

SilverSneakers Participation % Change

GREEN = % Change is equal to or greater than 0%
YELLOW = Not used
RED = % Change is less than 0%

Alerts Closed

The number of identified Humana Health Alerts during the reporting period in which the member completed the appropriate clinical action to close the gap in care and become compliant.

Alerts Fully Compliant

Members who have no open Humana Health Alerts.

Alerts Generated

Within the alerts categories, the number of alerts where recommended care is not present (non-compliant), based on Humana's clinical rules engine. These alerts are used by Humana Clinicians, Network Providers and Customer Care when interacting with members. Additionally, a message is automatically created and shared with members, when appropriate.

Alerts Percent Closed

Based on the number of alerts closed divided by the number of generated alerts.

Alerts Percent Compliant

The number of alerts in which member followed recommended care (includes the compliant alerts and those alerts which changed from non-compliant to compliant) divided by the number of situations that qualified for alerts during the reporting period. No action is needed by the member.

Alerts Qualified

The total number of times when Humana's clinical rules engine has enough information to determine if recommended care has been followed or not, and assign a compliant or non-compliant status for each alert.

Average Members

The sum of the number of members active at the end of each month during the reporting period divided by the number of months within the reporting period.

Average Population Age

The average age of all active members at the end of the reporting period.

Benign Tumors

A growth that is not cancer.

Brand Drug

A trademarked drug.

Coronary Artery Disease

Blockage in the blood vessels of the heart. (Coronary Artery Bypass Graft (history of), Percutaneous Transluminal Coronary Angioplasty (history of), Myocardial Infarction, Angina, Other Ischemic Heart Disease, Coronary Atherosclerosis).

Cancer

Cancer of all types. (Breast, Digestive, Upper Gastrointestinal, Lower Gastrointestinal, Pancreas/biliary/liver, Other, Respiratory, Upper Airway, Lower Airway, Genitourinary, Female Genital, Male Genital, Lower Urinary Tract, Upper Urinary Tract, Lymphatic & Hematologic, Secondary Cancer, Head and Neck, Skin and SubQ Tissue, Melanoma, Leukemia (certain)).

Case Mix Index

The average DRG weight for all inpatient cases paid. The Case Mix Index is a measure of the relative costliness of the patients treated in an inpatient setting. An index of 1.05 means that the facility's patients are 5% more costly than average.

Cerebrovascular Disease

Diseases that affect the blood flow to the brain. (Hemorrhage, Occlusion, Transient Ischemic Attack, Late Affects or complications of Cerebrovascular Accident).

Congestive Heart Failure

Impairment of the heart's muscle.

Chronic

Includes multiple conditions. (Other Heart Disease, Malignant Neoplasms, Diabetes, Chronic Kidney Disease, HIV and Related Conditions, Other Circulatory, Hypertension, Arteriosclerosis, Congestive Heart Failure, Endocrine, Thyroid Disease, Nervous System, Epilepsy, Musculoskeletal & Connective Tissue, Osteoporosis, Arthritis (other than RA), Respiratory, Asthma, Chronic Obstructive Pulmonary Disease, Digestive, Liver, Meningococcal Infection, Depression, Schizophrenia, Alcoholism).

Chronic Kidney Disease

Long-term kidney problems.

Chronic Obstructive Pulmonary Disease

Includes emphysema and chronic bronchitis.

Congenital Anomalies

Congenital Anomalies (Birth defects). (Heart, CNS, Digestive & Peritoneum, Genitourinary, Musculoskeletal).

Days / 1000 Members

The number of days admitted to an inpatient health care facility per thousand members, calculated for 12 month period.

Demographic Risk Score

Average risk score of all active members at the end of the reporting period. Each member's risk score is a mathematically-determined number that represents the effect of age and gender on expected medical costs.

Diabetes

A disease affecting how sugar is used in the body. (Neuropathy, Eye, Nephropathy, Peripheral Vasculary Disease).

Digestive

Includes diseases of the entire digestive system from the mouth to the intestines. (Upper Gastrointestinal, Peptic Ulcer Disease, Mouth/Jaw, Esophagus, Stomach/Duodenum, Lower Gastrointestinal, Pancreas/Biliary, Liver).

Division

A subgroup of a group used to identify a specific population.

Endocrine

Includes all diseases (except diabetes) caused when a large system of the body made up of glands and the hormones that they release, fails to work properly. (Thyroid Disease, Other Glandular Disorders, Other Metabolic and Immunity Disorders, Nutrition).

End Stage Renal Disease

Kidney failure requiring dialysis.

Exams and Preventive Services

These are costs associated with screening examinations, outpatient medical or surgical office visits, or routine types of follow-up care. (Exam & Screenings for Coronary Artery Disease, Other Heart Disease, Other Circulatory, Diseases of Blood and Blood-forming Organs, Malignant Neoplasms, Diabetes, Obesity, Endocrine, Genito-Urinary System, Congenital Anomalies, Rare Diseases, Nervous System, Sense Organs, Musculoskeletal & Connective Tissue, Infections, Respiratory, Digestive, Skin and SubQ Tissue, Injury and Poisoning, Mental Health and Infant/Child Care, Vaccination and Other - Includes Rehab).

Gap in Care

Gap in care clinical rules compare a member's medical history to industry standard Quality of Care guidelines in order to identify an alert that is non-compliant.

Generic

Common term to identify non-brand drugs that are equivalent to another drug, and are typically sold at a lower cost than brand drugs.

Genitourinary System

Includes diseases of male reproduction, female reproduction with the exception of pregnancy, and the urinary system. (Kidney/Ureter/Bladder, Male, Breast, Female).

Health Risk Behaviors

Includes care related not only to behaviors that an individual may be able to change, e.g. a smoker needing screenings for lung disease, but also hereditary conditions, e.g.. family history of heart disease, or an abnormal laboratory result, such as high blood sugar. (Obesity, Hyperlipidemia, Dysmetabolic Syndrome, Impaired Glucose/Insulin Resistance, Acanthosis Nigricans, Polycystic Ovary Syndrome, Smoking, Family History, Hypercoagulability).

Health Assessment

A series of questions about a member's physical health, eating habits, exercise patterns, general lifestyle, and mental health. Answers do not affect coverage, benefits, or premium for members.

Humana National Average

The average value for any measure for all Large Group Medicare members across Humana's book of business.

Infections

Including, but not limited to Candidal Infection, Mycobacteria & TB, Meningococcal Infection, Septicemia.

Injuries and Poisoning

Major injuries found under TRM (trauma). (Injury Major Organ, Drug Complications, Complicated).

Large Claimants

Members having more than $100,000 in medical and pharmacy claims paid during the reporting period.

Member Cost Share

The amount of the claim expense that is paid by the plan member through deductible, coinsurance, and copay amounts.

Musculoskeletal

Diseases of the bones, joints, and soft tissue. (Osteoporosis, Arthritis (other than RA), Back/Neck Pain, Anthropathies, Infections, Joint-Specific Disorders, Malformations, Soft Tissue Disorders)

Nervous System

Conditions that affect the brain and the nerves. (Inflammatory Diseases, Hereditary/Degenerative, Migraine, Epilepsy)

Other Circulatory

Multiple diseases that affect how the blood flows through the body, not listed elsewhere. Examples include: high blood pressure, blood clots and blockage, and abnormally widened arteries. (Hypertension, Essential Hypertension, Complicated, Arteriosclerosis, Aneurysms)

PMPM

Per Member Per Month. Calculated by dividing the sum of the number of active members at the end of each month in the reporting period (member months) into the raw number.

Prevalence

The number of members diagnosed with a specific condition divided by the average number of members active at the end of each month during the reporting period and expressed as a percentage.

Preventive Services

Humana typically labels claims as *preventive* based on the services listed below.

- Abdominal Aortic Ultrasound Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening;
  Including the procedures (but not exclusively): Barium Enema, CT, Colonography, Colonoscopy, Fecal Blood Occult, Radiological and Sigmoidoscopy
- Depression Screening
- Diabetes Screening
- Hearing Screening
- Hypertension Screening
- Immunizations;
  Including the vaccines for (but not exclusively): Influenza and Pneumonia
- Nutritional Counseling
- Osteoporosis Screening
- Other Cancer Screening
- Other Preventive Service
- Preventive Office Visits
- Prostate cancer Screening
- Sexually Transmitted Counseling
- Sexually Transmitted Disease Screening
- Substance Use/Abuse Counseling
- Vision Screening
- Weight Screening

Respiratory

Includes all conditions of the airway, from the nose and sinuses to the lungs (Asthma, Chronic Obstructive Pulmonary Disease, Infections, Allergies, Respiratory Failure.

SNF

Skilled Nursing Facility

Signs and Symptoms

Non-Specific Diagnoses. A specific diagnosis is not known or provided. (Coma, Altered Consciousness, Abdomen, Chest Pain, Death)

Sense Organs

Includes diseases of the eyes and ears. (Eye, Cataract, Glaucoma, Retinal Diseases, Visual Disturbance, Optic Nerve, Ear, External Ear, Middle Ear, Inner Ear)

Transplant

Includes both solid organ transplant such as kidney, heart, lung, and liver, and tissue such as bone marrow.

Trauma

Major injuries including those to the head, neck, and spine, mutiple fractures, and paralysis. (Skull fracture, Spinal cord fracture, Spinal Cord injury, Brain Laceration/Contusion/Concussion, Crushing Injury Face, Neck, Scalp, Paralysis, Hip Pelvis/Neck of Femur)

Urgent Care to ER

Urgent Care Visits per 1,000 members that resulted in a transfer to the Emergency Room.

Visits/1000 members

Visits by participants to health care providers per 1000 plan members, calculated on a yearly basis.

Attachment D
Account Management Team Resumes

Carla Whaley

Associate Vice President

Qualifications Overview

Carla is an accomplished and proven sales/account management executive with over 38 years committed to the "healthcare financing" industry in varying roles and positions. She is dedicated to helping clients, members, consultants/agents, and peers achieve their goals.

Background and Experience

Humana – Associate Vice President, Group Medicare

2012 – Present

- Represents national oversight for Group Medicare Account Management, includes 600+ clients with over 600,000 Group Medicare members nationwide
- Manages a team of 30+ associates, located across the country
- External facing, with responsibility for overall client and agent satisfaction
- Proven successful retention goals and profitable membership growth

Humana – Practice Leader

2007 – 2012

- Oversaw large public accounts in Kentucky, representing over 340,000 medical members, including the Commonwealth of Kentucky and Kentucky Teachers' Retirement System
- Spearheaded the development and deployment of Humana's first unique, customized Customer Relationship Management program

Humana – Vice President of Sales

1996 – 2007

- Responsible for 5,000 clients and 665,000 members
- Statewide responsibility for profitable membership growth for medical and ancillary product lines
- Directed a sales leadership team with a staff of up to 75 associates in both Louisville and Lexington

Education and Certifications

- Transylvania University; Bachelor of Science – Business Administration/Sociology; Presidential Scholar
- Kentucky Insurance State License; Life, Health and Accident
- 2006 "Woman of Achievement" Award through River City Business & Professional Women
- Greater Louisville Association of Health Underwriters Board of Directors
- Leadership Louisville and Leadership Kentucky Participant

Tiffany Calderon

Director of Account Management

Qualifications Overview

Tiffany is a native Texan spending the last 24 years building strong relationships across the insurance industry, specifically in sales and account management. Tiffany focuses on strong client professionalism and brings experience and knowledge managing large public sector clients to her team every day. She also has an eye for detail and a robust understanding of government contracts.

Background and Experience

Humana – Group Medicare Director of Account Management

August 2014 – Present

- Oversees an Account Management team focused on exceeding customer expectations, retaining membership, identifying opportunities to add value to clients, and generating growth for Humana
- Collaborates with internal teams responsible for the operational aspects including implementation/renewal, communications, and eligibility, billing and reporting. In addition to working closely with clinical guidance organization as well as provider relations to ensure both the client and member experience are positive
- Builds strategic relationships with new and existing customers by removing barriers, securing resources, providing consultative collaboration, sharing knowledge, and delivering on obligations
- Promotes year-round member engagement activities focused on plan education, member health and physical activity
- Responsible for managing public sector business covering over 450,000 commercial members and 230,000 Medicare Advantage retirees

Humana – Group Medicare Product Design Consultant

February 2005 – August 2014

- Directly responsible for managing client relationships, including contractual requirements, strategy, implementation, client and member engagement and education, reporting, and renewals
- Managed an assigned book of business consisting of both public and private sector commercial and Medicare clients
- Retained and grew membership of some of Humana's largest commercial clients in Texas through strategic planning and appropriate use of Humana's resources to engage eligible population

Education and Certifications

- University of Houston; Bachelor of Science – Psychology
- Insurance State License; Life, Health and Accident
- Resident License – Texas
- AHIP Certification
- President's Club Award; 2011, 2012
- President's Council Award; 2013-2018

Erin Dey

Senior Account Executive

Qualifications Overview

Erin started in the healthcare industry by managing the day-to-day operations of a 4,000-member self-fund health plan. She transitioned from being the client to servicing the customer at a former Louisiana based health insurer. From there she progressed into account management and held various operational roles. Erin brings her well-rounded experience and client understanding to her Group Medicare clients.

Background and Experience

Humana – Group Medicare Senior Account Executive

April 2014 – Present

- Works strategically with consultants, business leaders, and internal associates to provide excellent benefits and service
- Services numerous clients and retirees across the United States
- Manages both post- and pre-65 retiree plans for national organizations and labor groups
- Responsible for overall client experience and relationship with Humana

Humana – National Account Manager

November 2004 – April 2014

- Formed strong client relationships with large, nationwide accounts, including Chevron Corporation, AT&T, and Lockheed Martin
- Managed accounts with multiple Humana product offerings, including medical, dental, vision, and WVB
- Gained experience working with municipalities and unions

The Oath (a former Louisiana-based health plan) – Account Manager

1994-1997, 1998-2004

- Provided account management to multiple different clients, offering fully insured HMOs and PPO network rental/repricing services
- Managed customer service and claims and gained strong operational experience
- Monitored new hire training and established measures for quality review

Education and Certifications

- Tulane University; Bachelor of General Studies
- Insurance State License; Life, Health and Accident
- Resident License – Louisiana
- Non-Resident Licenses – Arkansas, California, Connecticut, Florida, Georgia, Illinois, Kentucky, Maryland, Michigan, New Jersey, New York, South Carolina, and Texas
- AHIP Certification

Maisie Mitchell

Account Installation Manager

Qualifications Overview

Maisie began her career at Humana in 2020 as a Group Medicare consumer engagement professional, focusing on planning and implementing member seminars to educate members on their benefits and additional resources available to them through their Group Humana plan. She quickly mastered the role, and in 2021, Maisie began working as a Group Medicare account installation manager.

Background and Experience

Humana – Group Medicare Account Installation Manager

2021 – Present

- Oversees and is responsible for overall implementation/renewal, including planning, strategizing, and communication of customized client-specific project plans
- Coordinates internal operational resources for planning and execution of overall project from point of sale through the effective date
- Schedules regular implementation/renewal calls with internal and external clients to strategize implementations
- Identifies process changes to enhance member and client experiences, often collaborating with internal business partners
- Facilitates accurate and timely reporting of data and metrics to internal and external business partners

Humana – Group Medicare Consumer Engagement Professional

2020 – 2021

- Oversight of annual enrollment, education, and wellness engagement for Group Medicare clients and their members
- Contributed to the business strategy by understanding benefit offerings to ensure enrollment success, facilitating member educational seminars, and directing members to available resources
- Collaborates with marketing, customer service, various vendor partners, and community resources to ensure a positive member experience with their Humana plan

Education and Certifications

- Louisiana State University, Master of Business Administration Candidate, 2023
- Ohio University, Master of Education, 2020
- Ohio University, Bachelor of Science, Health Services Administration, 2018

Christah Sykes

Communications Consultant

Qualifications Overview

Christah began her Humana career in April 2007. She started servicing Individual Medicare members and was quickly identified to be a mentor for her peers. Christah shares a passion for helping members understand and recognize how to utilize their health plan effectively. In 2014, Christah was requested to join an elite team of associates that serviced one of Humana's largest clients.

Background and Experience

Humana – Group Medicare Communications Consultant

2018 – present

- Maintains a working relationship with clients and all other team members to implement and maintain each group's communication strategy
- Creates enrollment materials specific to the client's requests and coordinates the mailing of these materials on a specific timeline
- Develops and plans enrollment and informational member seminars

Creates marketing materials consistent with Medicare Marketing Guidelines

Humana – Group Medicare Consumer Service Operations Professional

2014 – 2018

- Served as a designated Group Medicare employer point of contact assisting with escalated issues related to claims, benefits, billing, enrollment, and pharmacy
- Ensured call center associates had the tools, resources, and information necessary to service Group Medicare customers efficiently and effectively
- Connected with providers and provided education on Humana plan types and benefits
- Partnered closely with the Account Management team to ensure an exceptional consumer experience from pre-implementation through post enrollment period
- Provided on-site knowledge support to clients during transitional period

Humana – Group Medicare Service Operations Production Lead

2011 – 2014

- Provided guidance and leadership to team of 15 to 23 associates and served as a mentor for their day-to-day duties
- Analyzed data to guarantee key performance measures are met, while aiding in the removal of barriers to success
- Maintained proactive communication with other departments to ensure efficient, accurate and timely responses to internal/external customer needs were met

Education and Certifications

- Mid-Continent University; Bachelor of Science, Business Administration – Cum Laude
- Insurance State License; Life, Health and Accident
- Resident License – Kentucky

Courtney Bell

Account Concierge Specialist

Qualifications Overview

Courtney began her Humana career in 2012 as an operational specialist working enrollment or eligibility issues. She quickly advanced to a skilled Customer Care specialist providing the perfect experience for members. Because of her ability to adapt quickly and her dedication to service, Courtney joined the Group Medicare Account Concierge team in 2015. In this role, she uses her experience in customer service to resolve escalated issues for our members as efficiently as possible. Courtney also provides top-notch support at many Humana meetings throughout the country.

Background and Experience

Humana – Group Medicare, Account Concierge Specialist

2015 – Present

- Serves as a single point of contact for Group Medicare clients, supporting the customer in any service situation for any product in that customers plan
- Researches and resolves complex group-specific issues, analyzes to find root cause, and drives process improvements
- Works to ensure that contact center associates have the tools, resources and information necessary to service our Group Medicare customers efficiently and also helps develop and deliver training as needed
- Partners closely with the account management team to ensure and exceptional consumer experience from pre-implementation through post enrollment period
- Provides face-to-face customer service support during client meetings, open enrollment meetings, and Bringing Humana to You events

Humana – Customer Service Representative

2013 – 2015

- Addressed customer needs that included many complex benefit questions and resolved numerous issues as well as educated members
- Recorded details of all inquiries, comments, and/or complaints, transactions, and interactions and took action in accordance with each
- Escalated unresolved and pending customer grievances
- Assisted members and providers by resolving any concern or issue

Humana – Operational Pends Specialist

2012 – 2013

- Received and corrected annual enrollment applications
- Corrected eligibility issues and worked with internal teams to ensure accurate enrollment for members

Annie Eckert

Enrollment Analyst

Qualifications Overview

Annie Eckert is an enrollment analyst with the Group Medicare Operations department at Humana. Hired in 2010, Annie has spent her entire tenure with Humana in the Medicare realm, working in both Individual and Group Enrollment, as well as the Plan Load department where her responsibilities included interpreting and processing member benefit information. Annie's strengths include exceptional communication skills, Microsoft Office skills, and the ability to empathize with her members and groups. She is currently pursuing her Bachelor of Science in Health Science degree from Purdue University and intends to graduate in the fall of 2023.

Background and Experience

Humana – Medicare Service Operations, Group Enrollment Analyst

2020 – Present

- Researches and responds to enrollment inquiries from both internal and external partners, including group representatives
- Collaborates with multiple internal departments to ensure a seamless enrollment experience for our members and clients
- Reviews and provides enrollment reports to groups, including discrepancy reports, membership reports, critical error and incomplete enrollment reports
- Possesses a thorough understanding of the various CMS enrollment rules and guidelines and educate clients accordingly
- Assists clients with ensuring Open Enrollment files are received and processed in a timely manner

Humana – Medicare Plan Load

2012 – 2020

- Analyzed and interpreted New Plan Documents (NPD) containing plan benefits.
- Transferred data from NPD into internal system language for accurate claims payment.
- Maintained strict timelines for opening of benefits for claims payment.
- Created process improvements, create and maintain process documentation, and provide education.

Humana – Individual Medicare Enrollment Representative

2010 – 2012

- Reviewed pending Individual Medicare applications and resolved errors
- Trained new associates

Education and Certifications

- Purdue University, Global – Bachelor of Science in Health Science candidate

Attachment E
Sample Implementation Timeline

Jefferson Parish Government

Task	Start Date	End Date	Resource
Initial Implementation Requirements			
Complete Sold Notification Document (Sold Case Document)	**9/1/2022**	**9/1/2022**	Humana Sales Team
Conduct preliminary implementation meetings			Humana Installation Professional
Document unique needs for JPG to determine implementation team needs			Humana Installation Professional
Build implementation team			Humana Installation Professional
Conduct internal call with implementation team			Humana Installation Professional
Confirm plan sold and rates on Sold Case Document			Humana Installation Professional
Conduct external call, or onsite meeting, with JPG			Humana Installation Professional/JPG
Confirm plan sold and rates with JPG			Humana Installation Professional/JPG
Discuss enrollment needs			Humana Installation Professional/JPG
Collect JPG information			Humana Installation Professional/JPG
Enrollment method established			Humana Installation Professional/JPG
Finalize overall implementation plan			Humana Installation Professional/JPG
JPG Open Enrollment Period	**TBD**	**TBD**	JPG
Member Communications/Meetings			
Basic Requests	**TBD**	**TBD**	
Mail file for retirees			JPG
Send Humana the JPG logo to be used on member material			JPG
Determine group naming convention to be used in member material			JPG /Communications Consultant
Recommend communication materials and strategy, to include co-branding requirements and coordination			Communications Consultant/JPG
Establish mail file refresh schedule			Communications Consultant/JPG
Announcement Letter	**TBD**	**TBD**	**Timing based on JPG OE period**
Determine who will send the announcement letter to members			JPG /Communications Consultant
Humana to share draft of announcement letter			Communications Consultant
JPG to review and approve announcement letter			JPG
Humana to share final announcement letter			Communications Consultant
JPG approves final announcement letter			JPG
Announcement letter to reach retirees - **sent at least 2 months in advance of plan's effective date**			Communications Consultant
Informational Meetings	**TBD**	**TBD**	**Timing based on JPG OE period**
Provide mail file/census of eligible retirees to Humana			JPG
Meeting site location			Communications Consultant/JPG
Ongoing: Confirm attendees for meetings			Communications Consultant
Provide PowerPoint presentation for review			Communications Consultant

Task	Start Date	End Date	Resource
JPG to review and approve presentation			Communications Consultant
Determine material to have on hand for hand-outs to retirees			Humana Account Management/Communications Consultant/JPG
Determine seminar giveaways			Humana Account Management/Communications Consultant/JPG
Informational meetings conducted			Humana/JPG
Training/Preparation for Enrollment Meetings	**TBD**	**TBD**	**Timing based on JPG OE period**
Identify/contact inbound call team staff			Communications Consultant
Identify/contact Humana representative that will be presenting			Communications Consultant
Send materials to staff for training			Communications Consultant
Conduct webcast/on-site training for Humana staff			Communications Consultant
Ready to conduct informational meetings			Communications Consultant/Humana Agents
Informational Kit Material	**TBD**	**TBD**	**Timing based on JPG OE period**
Kit Cover Letter			
Share draft informational kit cover letter with JPG for review			Communications Consultant
JPG to provide feedback on the informational kit cover letter			JPG
Humana to share final informational kit cover letter			Communications Consultant
JPG to approve final informational kit cover letter			JPG
Summary of Benefits			
Share Summary of Benefits for review			Communications Consultant
JPG to provide additions to summary of benefits			JPG
Humana to share updated summary of benefits			Communications Consultant
JPG to approve summary of benefits			JPG

		Task	Start Date	End Date	Resource
		Enrollment Flyer			
		JPG to provide feedback on EDI flyer			JPG
		Humana to share draft of EDI flyer			Communications Consultant
		JPG to review and approve EDI flyer			JPG
		Humana to share final EDI flyer			Communications Consultant
		Guidebook			
		Humana to share Guidebook for review			Communications Consultant
		JPG to provide feedback on the Guidebook			JPG
		Humana to share updated Guidebook			Communications Consultant
		JPG to approve Guidebook			JPG
		Member to Provider Flyer			
		JPG to provide feedback on flyer			JPG
		Humana to share draft of flyer			Communications Consultant
		JPG to review and approve flyer			JPG
		Humana to share final flyer			Communications Consultant
		Seminar Invite			
		Humana to share invite for review			Communications Consultant
		JPG to provide feedback on seminar invite			JPG
		Humana to share updated seminar invite			Communications Consultant
		JPG to approve seminar invite			JPG
		Kit Folder			
		Humana to share kit folder for review			Communications Consultant
		JPG to provide feedback on co-branded Humana folder			JPG
		Humana to share updated co-branded Humana folder			Communications Consultant
		JPG to approve co-branded Humana folder			JPG
		Kit Mailing			
		Order approved kits for retirees			Communications Consultant
		Informational kits to reach retirees - should arrive at least 2 weeks prior to the first member meeting			Retirees
	Provider Directory Notice and Drug Guide		**9/15/2022**	**Ongoing**	
		Postcard notice shared with JPG			Communications Consultant
		Postcard mailed to enrolled members			Communications Consultant

Task	Start Date	End Date	Resource
Implementation Tasks			
Initial Implementation Tasks	***9/1/2022***	***Ongoing***	
Underwriting provides rates			Humana Underwriting
Review final approved rates			Humana Installation Professional
Submit to Group Setup for group number assignment strategy			Humana Installation Professional
Complete New Case Document			Humana Installation Professional
Internal review of New Case Document			Humana Account Management Team
Provide New Case Document to JPG for review			Humana Installation Professional
JPG sign off on New Case Document			JPG
Humana representative signs New Case Document			Humana Installation Professional
Review and confirm Contract, Retiree Program Summary, Review current plan design, and administration guides			Humana/JPG
Product Design/Development	***9/12/2022***	***9/23/2022***	
Create custom benefit grids			Humana Product Design
Create New Plan Document			Humana Product Development
Internal sign off from Plan Load and Design Team			Humana Product Development
Review of benefit grid(s)			Humana Installation Professional/Product Development team/JPG
JPG sign off on benefits			JPG
Plan Load	***9/26/2022***	***12/15/2022***	
Send New Plan Document to Plan Load			Humana Product Development
Load the benefit from New Plan Document			Humana Plan Load Team
Quality audit of benefits			Humana Medicare Service Operations
Testing of various claim scenarios			Humana Medicare Service Operations
Ready to open claims for payment			Humana Plan Load Team
Pharmacy Plan Load	***9/26/2022***	***12/31/2022***	
Part D Benefits sent to SS&C			Humana Pharmacy Team
SS&C loads benefits for Part D processing			Humana Pharmacy Team
Quality audit of loaded benefits			Humana Pharmacy Team
Testing of various claim scenarios			Humana Pharmacy Team
Ready to open claims for payment			Humana Pharmacy Team
Billing Setup	***9/1/2022***	***12/17/2022***	
Confirm billing method with JPG			Humana/JPG
Confirm billing contact at JPG			Humana/JPG
Confirm billing representative at Humana			Humana/JPG
Provide billing representative contact information to JPG			Humana Installation Professional
Review billing process with JPG			Humana/JPG
Ensure rates are reflected correctly in the system			Humana Installation Professional
Enrollment File	***9/12/2022***	***12/15/2022***	
Initial meeting with JPG to discuss EDI details and determine ongoing file delivery after implementation			Humana EDI Team/JPG

Task	Start Date	End Date	Resource
Electronic Transmission (ET) form sent to JPG to begin File Transmission Protocol (FTP) site setup			Humana Installation Professional
JPG returns completed ET form			JPG
FTP site setup is complete			Humana EDI Team
JPG sends test file			JPG
Review test file results			Humana EDI Team
Arrange for an updated test file to be sent			JPG
Review test file results			Humana EDI Team
Initial production file sent			JPG
Subsequent productions file(s) sent, as necessary			JPG
Resolve any discrepancies from file upload			Humana EDI Team
Determine all files received & loaded, Quality completed			Humana EDI Team
Quality check MA membership for accuracy			Humana Enrollment Analyst
Resolve any MA enrollment pends			Humana Enrollment Team
Resolve enrollment transmit status issues from CMS			Humana Enrollment Team
Submit enrollment on transmit file to CMS			Humana Enrollment Team
Enrollment Reporting and Processes	***9/12/2022***	***1/31/2022***	
Review enrollment processes and timing			Humana Enrollment Analyst
Review recurring enrollment discrepancy report layout			Humana Enrollment Analyst/JPG
Provide approval on recurring enrollment discrepancy report			JPG
Send recurring enrollment discrepancy report as scheduled			Humana Enrollment Analyst
ID Cards	***9/12/2022***	***Ongoing***	
Produce mock-up ID card for JPG review			Humana ID Card Team
JPG provides approval of mock-up			JPG
After members are enrolled, produce sample PDF for approval			Humana ID Card Team
Review and approve live ID card proof			Humana Installation Professional
Release the cards from the vendor			Humana ID Card Team
Confirmation of number of ID cards being mailed			Humana Installation Professional
Allow ongoing ID card production			Humana ID Card Team
New member processes	**9/12/2022**	**Ongoing**	
Define ongoing enrollment process (Post Implementation)			Humana/JPG
Confirm member material to mail			Communications Consultant/JPG
Update member material (if needed) and share for review			Communications Consultant
JPG review/approve new member material			JPG
Send new member material per established process			Communications Consultant
The new plan year begins	**1/1/2023**	**1/1/2023**	
Post Enrollment			
Reporting			
File Transmission Methods and Timing	N/A	N/A	
Review the file transmission methods for each reporting requirement and timing			Humana/JPG
Finalize transmission methods for all required reports and timing			Humana/JPG

Task			Start Date	End Date	Resource
	Mailings		**TBD**	**Ongoing**	
		Confirmation/Acknowledgment letter	TBD	Ongoing	Humana Medicare Service Operations
		Certificate - Evidence Of Coverage (EOC)	1/1/2023	1/31/2023	Humana Medicare Service Operations
		Health and Well-being Guide	2/1/2023	2/28/2023	Communications Consultant
	Clinical Initiatives		**1/1/2023**	**12/31/2023**	
		Humana at Home			Humana Clinical Team
		Humana Behavioral Health			Humana Clinical Team
		Utilization Management/Case Management			Humana Clinical Team
		Humana Health Alerts (Gaps in Care)			Humana Clinical Team
		Transplant Management			Humana Clinical Team
		Chronic Kidney Disease/ESRD			Humana Clinical Team
	Post-Implementation Wrap-up meeting		**TBD**	**TBD**	
		Post implementation meeting to review any issues			JPG
		Meeting to review the implementation process			Humana/JPG

Attachment F
Neighborhood Center Event Calendar

Featured events this August

Visit us online at HumanaNeighborhoodCenter.com to see a full list of virtual activities and to RSVP for classes and other events.

Metairie

747 Veterans Memorial Blvd.,
Metairie, Louisiana 70005
504-840-0906
Monday – Friday, 9:00 a.m. – 4:00 p.m.

FEATURED EVENTS

Foods to boost your brain power & Cooking demo

In person
August 9 | 10 a.m. CT

Can certain foods help boost your memory and help keep your mind sharp? Learn how your diet impacts brain health and which foods to focus on. Then, watch a chef prepare a recipe using brain-boosting foods.

Find relief from back pain

In person
August 16 | 10 a.m. CT

Back pain is not uncommon, and can easily affect your quality of life. Learn some of the causes and steps you can take to help prevent and reduce back pain.

Decompress from stress

In person
August 30 | 10 a.m. CT

Chronic stress may wreak havoc on your mind and body. Learn how to identify the areas in your life causing you the most stress and how simple changes may help you manage it.

Simple changes for managing cholesterol

In person
August 15 | 1 p.m. CT

Having too much cholesterol in your blood can cause serious health problems. Find out ways to help get your cholesterol levels within a healthy range – and keep them there.

Space is limited

Call your local Humana Neighborhood Center® at **504-840-0906** to RSVP for in-person events.

Can't make it in person?

No problem. Register for our online events by visiting **HumanaNeighborhoodCenter.com**.

You can also watch classes on demand by visiting **HumanaNeighborhoodCenter.com/Video-Library**.

SilverSneakers

Humana members with the SilverSneakers® benefit can access hundreds of classes and workout videos at no additional cost. Visit www.SilverSneakers.com to learn more.

Meet one on one—in person or over the phone—with a health educator or customer service representative. To schedule an appointment, call **504-840-0906 (TTY: 711)** or visit **HumanaNeighborhoodCenter.com.**

Humana.

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Metairie in-person events this August

Call **504-840-0906** today to RSVP. **Space is limited.**

Monday	Tuesday	Wednesday	Thursday	Friday
1 **1 - 2 p.m.** Craft corner: Photo magnet (Bring a photo)	**2** **10 - 11 a.m.** Meditation moment: Chronic pain (streamed)	**3** **10 - 11 a.m.** Bingo **2 - 3 p.m.** National watermelon day social	**4** **10 - 11 a.m.** Ask an agent: Over the counter benefits*	**5** **1 - 3 p.m.** Movie and popcorn: Knives Out (2013)
8 **1 - 2 p.m.** Paint and sip: Watercolor with Taylor Cohen	**9** **10 - 11 a.m.** Foods to boost your brain power	**10** **10 - 11 a.m.** National lazy day social: Wear your pajamas **2 - 3 p.m.** Game time: Cornhole	**11** **10 - 11:30 a.m.** Diabetes support series: Week 1	**12** **1 - 3 p.m.** Movie and popcorn: Ghostbusters: Afterlife (2021)
15 **1 - 2 p.m.** Simple changes for managing cholesterol	**16** **10 - 11 a.m.** Find relief from back pain	**17** **10 - 11 a.m.** Rock painting: M&M theme **2 - 3 p.m.** Game time: Connect four	**18** **10 - 11:30 a.m.** Diabetes support series: Week 2	**19** **1 - 3 p.m.** Movie and popcorn: The Kings Man (2021)
22 **1 - 2 p.m.** Paint and sip	**23** **10 - 11 a.m.** Simple changes for managing cholesterol	**24** **10 - 11 a.m.** Game time: Dominoes **2 - 3 p.m.** Seasonal allergies: Relief from wheezing and sneezing (streamed)	**25** **10 - 11:30 a.m.** Diabetes support series: Week 3	**26** **1 - 3 p.m.** Movie and popcorn: 335 (2022)
29 **1 - 2 p.m.** August birthday bingo	**30** **10 - 11 a.m.** Decompress from stress	**31** **10 - 11 a.m.** National trail mix social **2 - 3 p.m.** Game time: Yahtzee		

WEEKLY RECURRING EVENTS

Mondays	Tuesdays	Wednesdays	Thursdays	Fridays
10:15 - 11:15 a.m. SilverSneakers® Yoga*	**11:30 a.m. - 12:15 p.m.** Healthy cooking demo with Chef Nino (1) **12:30 - 1:15 p.m.** Healthy cooking demo with Chef Nino (2)	**12:15 - 1:15 p.m.** SilverSneakers® Stability*	**1 - 4 p.m.** Bridge and mahjong	**10 - 11 a.m.** Coffee and conversation

For accommodations of persons with special needs at meetings call, **504-840-0906 (TTY: 711)**.

* Humana Medicare Advantage members only.

Attachment G
Clinical Touchpoints for Group Medicare

Clinical Touchpoints

Humana delivers a suite of clinical programs to improve quality of care and control costs for Jefferson Parish and your members. All of our clinical programs and services are designed specifically for our senior members. By providing a holistic approach to care, we enable individuals to live longer, fuller lives in the comfort of their home. Humana understands the needs of seniors and has responded to the unique challenges of this population by investing in efforts to help them achieve and maintain their best health.

Humana's approach is rooted in human care: adapting healthcare to our changing environment by making experiences more personal and caring. We do this by enhancing members' access to care through the expansion of telehealth, in-home care services and technological advances that coordinate member health data. This offers affordable, accessible and flexible care options for seniors – where and when they need it.

Our programs offer the following:

- Affordable, accessible, and flexible home-based care options
- Comprehensive case and medical management approaches
- A rich data profile for each member, captured through claims data and clinical touchpoints
- Identification of condition severities and the best way to reach members and physicians
- One proprietary, integrated data system for our clinicians to access and share information in real time

We believe it's important to develop care support for retirees across every stage of health

Supported by Humana's ongoing commitment to promote whole-person health for all retirees

Healthy	Manageable conditions	Early stage disease and high-risk	Complex and chronic conditions
We engage and work with your healthiest members to maintain healthy lifestyles as they age and transition into new life phases.	Many members have manageable health conditions; we work with them to drive medication adherence and reinforce healthy lifestyles.	Members with early stage disease or at risk for negative health events have access to multiple hands-on programs to slow disease progression.	Your highest utilization members have access to the country's biggest network of home care professionals to provide the best possible care.
50% of members **15%** of costs	**25%** of members **15%** of costs	**20%** of members **35%** of costs	**5%** of members **35%** of costs
• voluntary In-home health and well-being assessment • Go365® and health coaching • SilverSneakers® • Humana Neighborhood Center® locations	• Humana Health Alerts • Virtual care • In-home care (house call) • Hospital in the home	• Telephonic case management • Utilization management (preauthorization services and claims review)	• End of life care services • Chronic kidney disease management • Oncology quality management • Transplant management
Focusing on social determinants of health no matter what stage of their healthcare journey			

Clinical programs and services for our healthy members

Voluntary in-home health and well-being assessment (IHWA)

An annual IHWA is a valuable tool that empowers even our healthiest members. An IHWA is a voluntary detailed annual review completed by a licensed health professional in the privacy of the member's home, providing an extra set of eyes and ears for their doctor. A licensed medical professional will spend 45 to 60 minutes of uninterrupted time with the member and results are shared both with the member and their primary care provider (PCP). Best of all, this is included with the Group Medicare Advantage plan at no additional cost.

The benefits of receiving the IHWA, even if the member is considered healthy, are tremendous and may include:

- Identification of gaps in care including fall risk, social determinants of health, and social isolation
- Support for the member in their wellness journey that includes preventive care for physical and mental well-being
- Clinical diagnosis through the use of diabetes and nephropathy (colon cancer) test kits
- A complete review of medications ensuring correct dosages and avoiding drug interactions
- Information about other Humana services that can help enhance their health or questions since their last doctor visit

Go365 by Humana™ and health coaching

Go365 is a voluntary member wellness solution offered to our Humana Group Medicare Advantage members. Go365 makes wellness fun and easy. Members are incented through the offering of gift cards* for completion of activities, including preventive annual wellness screenings, biometric screenings, participation in fitness/movement activities, bone density screenings, and flu shots. The program also has a social component that reduces loneliness and isolation among this demographic through virtual activities. Go365 also focuses on closing gaps in care and improving member health outcomes.

Go365 virtual activities

- Online health assessments create a personalized plan for the member to get moving, make healthier choices and earn rewards
- Virtual and local activities include posting on an online community or participating in nutrition webinars hosted by Humana
- Members accrue points redeemable for rewards by completing verified workouts with SilverSneakers® or by using an activity tracker
- Members can create health challenges to compete against friends and family

**Gift cards may present federal, state, and local tax consequences for Jefferson Parish. Any related taxes are solely your responsibility. Please consult your tax advisor.*

Health coaching services
Provided to our senior members through Go365 for Group Medicare Advantage members. This is a one-on-one, ongoing relationship between a coaching professional and a member, to help the member:

- Identify and set personal goals
- Go through the stages of the behavior change process
- Facilitate positive lifestyle changes such as tobacco cessation

Learn more at **Go365.com**.

SilverSneakers

SilverSneakers is the nation's leading voluntary fitness program designed specifically to keep seniors healthy. Humana Group Medicare Advantage members have access to more than 15,000 participating locations in the SilverSneakers network. A basic membership can include steam and sauna rooms, heated pools, body conditioning classes and strengthening tools in addition to exercise equipment and weights. Members may also participate in SilverSneakers classes offered at select locations and expanded virtual options. Classes are designed to increase strength, balance and flexibility and are led by instructors trained specifically in senior fitness.

Using proven methodologies based upon more than 25 years of science and outcomes, the SilverSneakers fitness program increases physical activity in seniors, often resulting in improved well-being and lower healthcare costs:

- **SilverSneakers FLEX classes** offer fitness options in the comfort of a familiar place, from community centers to nearby parks. Members have access to over 80 different types of classes, such as outdoor walking groups and nutrition workshops.
- **SilverSneakers virtual classes** began in 2020 and offer members the ability to engage in live virtual classes online or through the Go365 App. Virtual classes are offered every day of the week and members can participate from the comfort and safety of their home, offering members an opportunity to stay active and connected.
- **SilverSneakers On-Demand™ and SilverSneakers GO™** allow members to schedule workouts, find participating locations, access fitness programs on the go and track and schedule activities.

Learn more at SilverSneakers.com.

Humana Neighborhood Centers

Humana Neighborhood Centers are available to help visitors focus on their best health. Neighborhood centers offer a wide variety of voluntary special events, programs and activities such as healthy cooking demos, nutrition classes and more. Health educators are available to offer one-on-one health education and

may be able to connect individuals with community resources. Each location offers a unique calendar of special events, programs and activities designed to help improve physical and mental health. Various locations offer on-site customer care specialists that can answer plan benefit questions.

Staying socially distant doesn't mean the fun has to stop. We also host virtual activities such as crafting, book clubs and "coffee and conversation" to help visitors spend time with friends and make new connections. Humana Neighborhood Centers are currently operating with limited capacity by appointment only. We are moving slowly and thoughtfully to ensure that appropriate precautions and procedures are in place for the safety and well-being of our visitors and team members.

There are several ways to reach us:

- Online health and wellness classes: **Humananeighborhoodcenter.com**
- Scheduled phone or in-person appointments: **Humana.com/Humana-Neighborhood-Centers/Search**
- Facebook: **Facebook.com/Humana**

Clinical programs and services for our members with manageable conditions

Humana Health Alerts (gaps in care messaging)

Each member comes with a different health history and concerns. Humana provides personalized, proactive and preventive outreach to give members the support they need when gaps are identified and the tools to help them stay healthy. Our goal is to promote healthy habits with outreach and engagement. Humana may engage with members through email, letter, automated calls, customer care notifications or text messages. In some cases, if the gap is for a serious condition, the member may receive a call from a Humana nurse and contact will be made with the physician.

Humana analyzes the information received for all members including medical and pharmacy claims, lab results, biometrics and more, building a rich health data profile of each member. Data is run through our rules engine, which applies clinical and business rules, so we can accurately identify members with potential health issues and route them to the most appropriate support. The rules engine automatically recognizes when members are not getting recommended care. These gaps in care may be preventive (such as a member missing immunizations) or disease-specific (such as annual exams for diabetics) or may involve care modification (such as addressing potentially harmful drug-to-drug or drug-to-disease interactions).

Virtual care

A virtual visit — also known as telehealth or telemedicine — is an option available to our members that makes it easy to access care from a board-certified doctor via a secure video or phone appointment for a wide variety of non-emergency conditions. Doctors may even be able to prescribe medication for the member. There is no need for members to travel, no need to sit in waiting rooms and no surprise urgent care or emergency room (ER) medical bills.

Members have access to board-certified providers for internal medicine, family practice, emergency medicine, pediatrics and dermatology as well as licensed psychiatrists and mental health professionals. All virtual care providers can treat for a wide range of conditions including (but not limited to) allergies, fever, cold and flu symptoms, sinus infection, constipation or diarrhea, insect bites, depression, anxiety, stress and family or relationship counseling.

Members can use Humana's Find a Doctor tool (**Finder.Humana.com**) and select "Virtual" if they prefer this to an in-person visit or call the number on the back of their member ID card to get connected with a provider.

In-home care

Through Humana's partnerships, members now have more options than ever before to access high-quality care without leaving the comfort of their homes. In-home care offers quality care from licensed providers. This is a safe, convenient and in-network alternative to in-office care. Depending on the type of provider, in-home care may include primary care, pediatrics, urgent/emergency care and other types of care. This care may include administration of laboratory tests, treatments and procedures and prescribing medications in some cases.

In-network provider partners for in-home care include expert partners such as Heal and Dispatch and are rapidly expanding depending on the member's location. Members can locate providers in their area through Humana's Find a Doctor tool (**Finder.Humana.com**). By selecting "House Call" in the search criteria, members can identify providers in their area.

Hospital in the home

Humana continues to expand in-the-home solutions that deliver care for members' health needs, so they can stay home and recover safely, saying goodbye to uncomfortable waiting rooms or hospital stays. The option to choose healthcare in the comfort of their home helps reduce unnecessary ER visits and hospitalizations, improve clinical outcomes, and decrease burdensome costs for the overall healthcare system.

Urgent care
Members now have the option to have qualified practitioners provide in-home urgent treatment for a wide array of non-life-threatening medical conditions 365 days a year. The process is simple: members request care over the phone or via our app or website by selecting "House Call" in our Find a Doctor tool (**Finder.Humana.com**).

A team of qualified medical practitioners, including a nurse practitioner or physician assistant and a medical technician, will be sent to the member's home. Treatment encompasses nearly every urgent (but not life or limb threatening) condition that an ER can and may also help patients manage the side effects of complex medical conditions. During an emergency, a member should call 911 or go to the nearest ER.

Home hospital care
Home hospital care gives patients the option to recover from certain acute or post-acute conditions and surgical procedures in their own home instead of a hospital or skilled nursing facility. This solution enables a new standard of care for at-home hospital services for provider partners and payers like Humana. In partnership with health systems, home hospital care offers a safe and effective alternative to a traditional inpatient hospital stay. Home hospital care offers comfort and safety by sending eligible patients home from emergency departments and urgent care to receive hospital-level care. This typically consists of an acute phase and a monitoring phase, during which care coordination and ongoing monitoring of the member's condition takes place.

Clinical programs and services for our members with early stage disease and higher-risk

Telephonic case management

Case management provides telephonic support to members on a voluntary basis when they are at risk for problems associated with acute and/or chronic healthcare needs. Case managers assess opportunities to coordinate care, efficiently utilizing the continuum of care and managing the member's full spectrum of care to optimize outcomes while helping individuals live their best possible lives at home. Case management at Humana helps to reduce healthcare costs, improve clinical quality, and drive customer satisfaction.

Our case management program includes:

- **Post-discharge care coordination**: Short-term post-discharge support for members most at risk for readmission. Care managers will complete a comprehensive post-hospital evaluation that includes medication adherence/reconciliation, support and assistance, follow-up appointments and evaluation of additional service needs (DME, home health, transportation, etc.) and education needs.
- **Post-discharge nutritional support (Humana Well Dine Meal Program):** Our Well Dine food assistance program provides short-term nutritional support at no additional cost to our members. Well Dine is intended to lower readmission rates to hospitals or skilled nursing facilities by providing prepared meals to seniors who live alone and might not have access to proper nutrition. An inpatient benefit is available following a member's overnight stay in a hospital or skilled nursing facility. If the member chooses this support, 10 pre-cooked frozen meals are delivered to the member's home.
- **Social worker assistance**: Social workers can assist members with financial barriers for certain costs using programs like Extra Help, pharmacy assistance programs and other savings programs. They also can help with transportation and meals, as well as other social factors that may impact a member's overall physical and mental well-being.
- **Behavioral health**: This service is provided by behavioral health subject matter experts. The program supports members who are experiencing an acute behavioral health need by connecting them with in-network behavioral health professionals for behavioral health or substance use disorder treatment. Members can also benefit from behavioral health resource referrals, education on behavioral health symptoms and coping and matching of healthcare benefits with suitable qualification for all Humana programs.
- **Complex case management (CCM):** This program provides complex case management and includes post-discharge support, comprehensive assessment, care planning, education and medication reconciliation to members with complex needs and conditions, including behavioral health and other referrals as needed.

Utilization Management (UM): preauthorization services and claims review

Humana conducts pre-authorization and UM for several specialized conditions. Using a peer-to-peer review process working directly with the member's provider, we manage care using proven and predictable

evidence-based models that help ensure the best health outcomes, while controlling unnecessary costs in the following UM areas:

- **Preauthorization and prospective management inpatient and outpatient:** Clinical review includes determination of whether requested services are a covered benefit and if medical necessity guidelines are met. Providers may review services requiring preauthorization or referral via Availity.com.
- **Inpatient admission/concurrent review:** Clinical review to determine if services are included as a covered benefit, meet medical necessity guidelines and are at the appropriate level of care and for the optimal length of stay.
- **Discharge planning:** Clinical collaboration with the facility's discharge planning staff to promote early identification of any gaps or barriers in the planned transition to the appropriate next level of care. The goals of the discharge planning program are to avoid readmissions and unnecessary ER visits, coordinate any medical services still needed or unaddressed and promote timely follow-up care after discharge.
- **Retrospective review:** Humana network providers are contractually obligated to comply with medical management processes and procedures. All non-emergency hospital admissions need to be preauthorized by the PCP, the attending physician and/or the facility. If preauthorization was not obtained, claims administratively deny for no preauthorization, and the provider can submit medical records along with a request for retrospective medical necessity review.

Clinical programs and services for our members with complex and chronic conditions

End-of-life care services

Too often patients selecting hospice care do so in the final days or weeks of life, rather than at the start of their eligibility. As a result, patients and their families miss an opportunity to take full advantage of a wide range of benefits, including improved access to palliative care and caregiver support, as well as important transitional care services. Humana's goal is to allow for a continuous care team through our care management program, which can offer guidance and support.

Palliative care
Palliative care offers an extra layer of physical and emotional support to members and their families throughout the course of a member's illness to improve their quality of life and reduce risk of hospitalizations. The health team consists of physicians, nurse practitioners, nurses, chaplains and social workers offering a blend of home and telehealth services to members while they receive curative treatments. This helps to ensure that members receive the care they want, in the location where they want it and at the time they need it. This is not a hospice service and members participating may continue to seek any curative treatments they wish.

Hospice/end-of-life care
Upon agreement from the member and physician, hospice evaluations can be coordinated by our care management team. Care managers follow up by telephone to assist in completion of paperwork, to ensure appropriate services are in place to avoid unnecessary hospital visits and to make members feel as comfortable as possible. Caregiver support and respite care are sometimes arranged for family members, and additional community resources for meal services or transportation may also be offered at this time.

Our care managers include end-of-life planning questions in their comprehensive assessment and provide individualized education and care planning. Care managers can also send members more information in the form of the Five Wishes Living Will document or the MyDirectives advance care planning tool, which members may access through their Humana plan. If members have questions about hospice, care managers can assist with outreach to the treating physician.

MyDirectives
While many people say it is important to put their wishes in writing, only 37% have completed it, according to an analysis by the journal Health Affairs. Humana currently offers Group Medicare members MyDirectives, an online tool that allows a member to create a universal digital advance directive that can be shared and accessed by approved family and physicians at any time. With MyDirectives, members can make their exact wishes known, as well as what they value most in their lives. Members can make changes to their advance care plans and MyDirectives makes them immediately accessible. If a member already has an advance care plan, they can upload their existing document to securely store or easily share with their physicians and family members to have it in a time of need.

The MyDirectives tool covers advance care planning for the following areas:

- Home healthcare, assisted living, nursing care or hospice care
- Types of treatment
- Living will and medical power of attorney
- Prolonged life support, including resuscitation wishes
- Comfort (palliative) care
- Organ donation and autopsy preferences

Chronic kidney disease management

Humana is driving best practice disease management of chronic kidney disease (CKD) and End-Stage Renal Disease (ESKD) management in Humana members through delaying progression of the disease combined with better transitions into dialysis care. CKD and ESKD management provides individual care guidance, education and care coordination for individuals with specific kidney-related needs. Depending on location and condition severity, members with late stage (stage 4 + stage 5) CKD or ESKD may have access to care support via telephone or in-person at their home or dialysis center. Humana will outreach to eligible patients for enrollment. These comprehensive care coordination programs are designed to educate participants and coordinate the multiple facets of their care, including:

- Member assessment and care planning
- Case management and care coordination
- Member education (including medication compliance)
- Application of protocols and guidelines to prevent or control the development of comorbid conditions

Using nationally accepted practice guidelines, programs work with local nephrologists and dialysis centers to develop efficient care management for program participants. Care coordination promotes the most cost-effective use of resources by helping patients get the most appropriate healthcare, social and support services.

Oncology quality management (OQM)

Humana's OQM program, founded on evidence-based care, uses a peer-to-peer model within traditional preauthorization management for chemotherapeutic drugs, symptom management drugs and supporting agents. The focus of the program is to improve adherence to evidence-based care, while using the most effective treatment plans with the lowest toxicity and the fewest side effect risks. All participating oncology specialists are required to participate with their respective program.

Transplant management

Humana offers our National Transplant Network as a Center of Excellence (COE) program to members who need high-cost, highly-specialized transplant procedures. Each transplant facility in our network is chosen based on a review of the program's outcomes, annual volume, survival rates and accreditation. We negotiate

network contracts with leading transplant centers strategically located throughout the United States to best serve our members. Once members are identified and referred to the program, their dedicated clinician works with them and their provider during the planning stages, the procedure, the hospital stay, and for one year post-transplant.

Our transplant facilities with experience in ventricular assist devices (VAD) for both transplant patients and destination therapy are also a COE. VAD use is growing, and through our COE program, we direct members to hospitals with experience in successfully implanting these expensive devices in a cost-effective manner.

Attachment H
Audited Financial Reports

Humana Health Benefit Plan of Louisiana, Inc.

(a wholly owned subsidiary of Humana Insurance Company, a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2020 and 2019

Humana Health Benefit Plan of Louisiana, Inc.
Index
Statutory Basis of Accounting
December 31, 2020 and 2019

Report of Independent Auditors

To the Board of Directors of Humana Health Benefit Plan of Louisiana, Inc.

We have audited the accompanying statutory financial statements of Humana Health Benefit Plan of Louisiana, Inc., which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2020 and 2019, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the state of Louisiana. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2020 and 2019, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Louisiana described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2020 and for the year then ended are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the statutory-basis financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 29, 2021

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Admitted Assets		
Cash and invested assets		
Bonds	$ 452,035,075	$ 404,723,770
Receivable for securities	16,750	5,431
Short-term investments	-	1,500,305
Total invested assets	452,051,825	406,229,506
Cash	69,140	(3,000,915)
Cash equivalents	119,112,724	26,303,500
Total cash and invested assets	571,233,689	429,532,091
Premiums receivable	32,786,060	33,027,843
Investment income due and accrued	4,067,856	3,954,602
Amounts receivable relating to uninsured plans	11,293,207	8,444,091
Health care and other receivables	39,667,833	34,840,491
Net deferred tax assets	6,223,976	4,245,695
Electronic data processing equipment and software, less accumulated depreciation of $4,813 and $0 in 2020 and 2019, respectively	72,193	-
Furniture and equipment, less accumulated depreciation of $842,812 and $701,078 in 2020 and 2019, respectively	719,533	775,406
Receivable from Humana Inc.	8,188,052	16,197,204
Total admitted assets	$ 674,252,399	$ 531,017,423
Liabilities		
Benefits and loss adjustment expenses payable	$ 282,873,684	$ 210,151,227
Aggregate health policy reserves	22,651,755	20,481,174
Aggregate health claim reserves	236,869	142,000
Advance premiums	6,807,644	5,084,272
Accounts payable and accrued expenses	15,655,093	12,104,169
Current federal income tax payable	938,452	3,419,725
Total liabilities	329,163,497	251,382,567
Surplus		
Common stock, $0 par value; $1 per share stated value; 1,000 shares authorized; 1,000 shares issued and outstanding	1,000	1,000
Special surplus - projected HCRL fee assessment	-	44,204,567
Paid-in surplus	66,400,346	66,400,346
Unassigned surplus	278,687,556	169,028,943
Total surplus	345,088,902	279,634,856
Total liabilities and surplus	$ 674,252,399	$ 531,017,423

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Earned premiums	$ 2,582,581,489	$ 2,250,677,753
Expenses		
Benefits incurred and loss adjustment expenses	2,173,613,296	1,967,334,040
Selling, general and administrative expenses	281,412,042	199,602,237
Changes in aggregate health policy reserves	1,950,870	1,605,000
Total expenses	2,456,976,208	2,168,541,277
Net underwriting gain	125,605,281	82,136,476
Net investment income	10,682,504	13,201,421
Net realized capital (losses) gains on investments (net of capital gains tax of $458,917 and $37,154, respectively)	(253,385)	139,768
Net other income (expense)	64,828	(239,814)
Income before federal income tax expense	136,099,228	95,237,851
Federal income tax expense	36,709,614	20,603,283
Net income	$ 99,389,614	$ 74,634,568

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2019	1,000	$ 1,000	$ -	$ 65,760,152	$ 187,105,363	$ 252,866,515
Net income	-	-	-	-	74,634,568	74,634,568
Projected HCRL fee assessment	-	-	44,204,567	-	(44,204,567)	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	148,313	148,313
Change in net deferred income taxes	-	-	-	-	1,202,134	1,202,134
Change in nonadmitted assets	-	-	-	-	143,132	143,132
Forgiveness of payable from Humana Inc.	-	-	-	640,194	-	640,194
Dividends or return of capital paid	-	-	-	-	(50,000,000)	(50,000,000)
Balances at December 31, 2019	1,000	1,000	44,204,567	66,400,346	169,028,943	279,634,856
Net income	-	-	-	-	99,389,614	99,389,614
HCRL fee moratorium	-	-	(44,204,567)	-	44,204,567	-
Change in net deferred income taxes	-	-	-	-	2,009,914	2,009,914
Change in nonadmitted assets	-	-	-	-	(8,445,482)	(8,445,482)
Dividends or return of capital paid	-	-	-	-	(27,500,000)	(27,500,000)
Balances at December 31, 2020	1,000	$ 1,000	$ -	$ 66,400,346	$ 278,687,556	$ 345,088,902

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Cash flows from operations		
Premiums collected	$ 2,584,551,650	$ 2,239,951,121
Net investment income received	14,787,237	17,322,837
Benefits paid	(2,029,002,548)	(1,854,576,373)
Selling, general and administrative expenses paid	(362,554,924)	(283,011,596)
Federal income taxes paid	(39,649,804)	(15,744,914)
Net cash from operations	168,131,611	103,941,075
Cash flows from investments		
Proceeds from investments sold or matured	137,285,072	93,515,823
Cost of investments acquired	(188,620,151)	(59,912,657)
Net cash (used for) from investments	(51,335,079)	33,603,166
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(27,500,000)	(50,000,000)
Other cash provided (applied)	5,082,442	(60,218,398)
Net cash used for financing and miscellaneous sources	(22,417,558)	(110,218,398)
Net change in cash, cash equivalents and short-term investments	94,378,974	27,325,843
Cash, cash equivalents and short-term investments		
Beginning of year	24,802,890	(2,522,953)
End of year	$ 119,181,864	$ 24,802,890

The accompanying notes are an integral part of these statutory basis financial statements.

1. Reporting Entity

Humana Health Benefit Plan of Louisiana, Inc. (the Company), a wholly owned subsidiary of Humana Insurance Company (HIC), a wholly owned subsidiary of CareNetwork, Inc. (CNI), a wholly owned subsidiary of Humana Inc. (Humana), is a health maintenance organization (HMO) domiciled in the state of Louisiana and is authorized to sell health plan products therein. The Company is subject to regulation by the federal government and the Louisiana Department of Insurance (the Department). State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 7, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 6.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 10(a).

As part of the Company's individual Medicare Advantage products, it also offers Dual Eligible Special Needs (D-SNP) plans. In connection with offering a D-SNP plan in a particular state, the Company is required to enter into a special coordinating contract with the applicable state Medicaid agency.

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the Department, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(m), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Comprehensive income disclosures required by GAAP are omitted; and

viii. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

ix. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The Department adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The Department has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. The Commissioner of Insurance of the State of Louisiana allows the Company to admit its furniture and equipment used for Health Maintenance Organization operations, which is not in accordance with NAIC SSAP. The omission of this prescribed practice would have had no impact to the results of the Company's risk-based capital calculations.

The statutory financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department. A reconciliation of the Company's net income and surplus based on practices prescribed by the Department to net income and surplus based on Codification at December 31, 2020 and 2019 is shown below:

	2020	2019
Net Income – State of Louisiana basis	$ 99,389,614	$ 74,634,568
State prescribed or permitted practices	-	-
Net Income – Codification	$ 99,389,614	$ 74,634,568
Surplus – State of Louisiana basis	$ 345,088,902	$ 279,634,856
State prescribed or permitted practices		
a. Furniture and equipment	(719,533)	(775,406)
Surplus – Codification	$ 344,369,369	$ 278,859,450

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage (MA) premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases the Company's effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021. The annual health insurance industry fee levied on the insurance industry was $15.5 billion in 2020.

The 2020 annual health insurance industry fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A segregation was recorded within special surplus for the annual health insurance industry fee related to the 2019 data year for the 2020 fee. The 2020 health insurance industry fee was paid September 30, 2020. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2020 and 2019 were as follows:

	2020	2019
HCRL fee assessment payable	$ -	$ 44,204,567
HCRL fee assessment paid	41,987,405	-
Premium written subject to HCRL 9010 assessment	-	2,223,799,173
Total Adjusted Capital Level before surplus adjustment	345,088,902	279,634,856
Total Adjusted Capital Level after surplus adjustment	345,088,902	235,430,289
Authorized Control Level after surplus adjustment	73,617,376	65,262,954

It is reasonably possible that the HCRL and related regulations, as well as other current or future legislative, judicial or regulatory changes, such as the Families First Coronavirus Response Act (the "Families First Act"), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES

Act") and other legislative or regulatory action taken in response to COVID-19 including restrictions on Humana's ability to manage its provider network or otherwise operate its business, or restrictions on profitability, including reviews by regulatory bodies that may compare its MA profitability to its non-MA business profitability, or compare the profitability of various products within its MA business, and require that they remain within certain ranges of each other, increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, or increases in regulation of Humana's prescription drug benefit businesses, in the aggregate may have a material adverse effect on Humana's results of operations, (including restricting premiums, enrollment and premium growth in certain products and market segments, restricting Humana's ability to expand into new markets, increasing its medical and operating costs, further lowering its Medicare payment rates and increasing its expenses associated with assessments); its financial position; and its cash flows.

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, create uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. **Cash, Cash Equivalents and Short-Term Investments:** The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Short-term investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. **Investments:** Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the

investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds, cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2020 or December 31, 2019.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2020 or 2019.

For other restricted assets reported in aggregate, the pledged amounts with the Department were $1,250,000 and $1,000,000, which is 0.18% and 0.19% of gross assets and 0.19% and 0.19% of net admitted assets, at December 31, 2020 and 2019, respectively. These investments, generally certificates of deposit, were on deposit at December 31, 2020 and 2019 to satisfy requirements of regulatory agencies. These assets are included in cash and bonds in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

e. Fair Value: In accordance with SSAP No. 100R, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2020 or 2019.

The Company did not have any financial assets carried at fair value in the accompanying statements of admitted assets, liabilities, and surplus as of December 31, 2020 and 2019.

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2020 and 2019 were as follows:

	December 31, 2020					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and cash equivalents	$ 587,750,171	$ 571,147,799	$ 77,996,977	$ 509,753,194	$ -	$ -

	December 31, 2019					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 441,692,148	$ 432,527,575	$ 26,303,500	$ 415,388,648	$ -	$ -

f. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other income (expense) in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from 3 to 10 years. Depreciation expense, including that related to the nonadmitted portion, was $146,548 and $194,774 for the years ended December 31, 2020 and 2019, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $182,351 and $221,052 for the years ended December 31, 2020 and 2019, respectively.

g. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2020 and 2019 DTAs of $172,075 and $140,442, respectively, were nonadmitted.

h. **Earned Premiums:** Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for its membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022.

The amount of net premiums written by the Company in 2020 and 2019 that were subject to retrospective rating features were $2,505,288,743 and $2,196,056,462, respectively, or 97.01% and 97.57%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $23,096,271 and $30,255,445 as of December 31, 2020 and 2019, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company did not have any rebates incurred, paid or unpaid as of December 31, 2020 and 2019.

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

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as define by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the

contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2020 and 2019:

	2020		2019	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 3,403,311	$ -	$ 499,862	$ -
Amounts receivable relating to uninsured plans	-	11,293,207	-	8,444,091
Aggregate health policy reserves	(2,140,108)	-	(1,892,346)	-
Accounts payable and accrued expenses	-	(10,094,972)	-	(5,013,876)
Net asset (liability)	$ 1,263,203	$ 1,198,235	$ (1,392,484)	$ 3,430,215

j. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health

insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company risk adjustment data for 2018 and 2019 was selected for audit by HHS. The final assessment from this audit was immaterial to the statutory statements of revenues and expenses.

The temporary risk corridor program applied to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including the Company's small group health plans, were not subject to the risk corridor program. The risk corridor provisions were included to limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to the Company or require it to refund HHS a portion of the premiums the Company received.

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2020 and 2019:

HCRL Risk Adjustment		
Assets	**2020**	**2019**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 2,900,060	$ 310,364
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	16,485	24,225
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	-	154,529
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	1,985,298	(800,019)
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	13,821	22,532

HCRL Risk Corridor		
Assets	**2020**	**2019**
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	6,513,426	-
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 415,970	$ -	$ 415,970	$ -	$ -	$ -
2015	3,073,968	-	3,073,968	-	-	-
2016	3,092,926	-	3,092,926	-	-	-
Total	$ 6,582,864	$ -	$ 6,582,864	$ -	$ -	$ -

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government for payments under the risk corridor premium stabilization program established under the HCRL for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, the Company received $6,513,426 from the U.S. Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $6,513,426 payment received from the U.S. Government and $325,573 in related fees and expenses are reflected in net premium income and selling, general and administrative expenses, respectively.

A roll-forward of risk corridor assets, gross of any nonadmissions and liability balances by program year, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before Dec 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before Dec 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 -3)	Prior Year Accrued Less Payments (Col 2 -4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium	-		346,532		(346,532)		346,532		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
b. 2015											
1. Accrued retrospective premium	-		3,073,968		(3,073,968)		3,073,968		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
c. 2016											
1. Accrued retrospective premium	-		3,092,926		(3,092,926)		3,092,926		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
d. Total for Risk Corridors	-	-	6,513,426	-	(6,513,426)	-	6,513,426	-		-	-

Explanations of adjustments

A. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

The transitional reinsurance program required the Company to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the HCRL in the individual commercial market were eligible for recoveries if individual claims exceed a specified threshold. Accordingly, the Company accounted for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in its statutory statements of revenue and expenses. The Company accounted for contributions made by individual commercial plans compliant with the HCRL, which were subject to recoveries, as ceded premiums (a reduction of earned premiums) and similarly the Company accounted for any recoveries as ceded benefits (a reduction of benefits incurred and loss adjustment expenses) in its statutory statements of revenue and expenses.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2020 and 2019:

	2020	2019
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ -
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	-	38,958
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	310,364		216		310,148		2,458,368		A.	2,768,516	
2. Premium adjustments (payables) (including high risk pool payments)		(154,529)		(759,144)		604,615		(604,615)	B.		-
3. Subtotal ACA Permanent Risk Adjustment Program	310,364	(154,529)	216	(759,144)	310,148	604,615	2,458,368	(604,615)		2,768,516	-

b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		-		-		-			-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance-not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		6,513,426		(6,513,426)		6,513,426		C.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	6,513,426	-	(6,513,426)	-	6,513,426	-		-	-
d. Total for ACA Risk Sharing Provisions	310,364	(154,529)	6,513,642	(759,144)	(6,203,278)	604,615	8,971,794	(604,615)		2,768,516	-

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2019 benefit year and the latest data from Wakely Consulting.

B. Small Group estimate changes for unfinalized years, based on latest data from Wakely Consulting.

C. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

Net collections and payments under the 3Rs associated with prior coverage years were $5,754,498 and $(2,257,433) in 2020 and 2019, respectively.

k. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate

of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 8. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2020, 2019, and 2018:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2020	$ 38,575,173	$ 38,575,173	$ -	$ -	$ -
9/30/2020	51,140,722	51,140,722	50,802,132	-	-
6/30/2020	55,826,262	55,826,262	55,355,084	346,063	-
3/31/2020	44,038,822	44,038,822	43,108,835	883,660	26,776
12/31/2019	32,409,099	32,409,099	32,211,775	-	-
9/30/2019	37,222,346	37,222,346	36,963,112	72,501	186,733
6/30/2019	56,554,808	56,554,808	55,832,379	219,447	471,808
3/31/2019	39,411,645	39,411,645	39,018,971	-	392,674
12/31/2018	29,286,451	29,286,451	28,890,678	205,376	95,727
9/30/2018	35,112,475	35,112,475	34,969,900	142,575	-
6/30/2018	46,560,483	46,560,483	46,344,117	216,366	-
3/31/2018	32,699,931	32,699,931	32,699,931	-	-

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $806,424 and $1,104,438 were nonadmitted at December 31, 2020 and 2019, respectively.

I. **Benefits Incurred and Loss Adjustment Expenses:** Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $3,877,001 and $2,021,000 at December 31, 2020 and 2019, respectively, which are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

m. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

n. Going Concern Considerations: Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, Management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

o. Reclassifications: Certain prior year amounts have been reclassified to conform to the 2020 financial statement presentation. These reclassifications have no impact on the Company's reported surplus, net income, or net cash flows.

p. Subsequent Events: The Company evaluated subsequent events through April 29, 2021, the date these financial statements were issued or available to be issued.

On March 25, 2021, the Company requested to pay a dividend to its parent HIC of $100,000,000, of which, $65,500,000 was extraordinary. The Company received approval to pay the dividend from the Department on April 19, 2021. The Company has not yet paid the dividend.

The Company is not aware of any other events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2020 and 2019 were as follows:

	2020			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 5,224,148	$ 280,716	$ -	$ 5,504,864
States, territories and possessions	103,208,147	3,255,090	(76,568)	106,386,669
Political subdivisions of states, territories and possessions	59,321,801	2,356,543	(2,058)	61,676,286
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	152,946,563	5,018,986	(96,151)	157,869,398
Industrial and miscellaneous	131,334,416	5,865,814	-	137,200,230
Hybrid Securities	-	-	-	-
Total bonds	$ 452,035,075	$ 16,777,149	$ (174,777)	$ 468,637,447

	2019			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 5,917,815	$ 114,078	$ (27,067)	$ 6,004,826
States, territories and possessions	73,422,668	2,447,292	(810)	75,869,150
Political subdivisions of states, territories and possessions	56,152,055	1,221,393	(58,447)	57,315,001
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	130,494,906	2,777,785	(192,874)	133,079,817
Industrial and miscellaneous	138,736,326	2,997,160	(113,937)	141,619,549
Hybrid Securities	-	-	-	-
Total bonds	$ 404,723,770	$ 9,557,708	$ (393,135)	$ 413,888,343

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2020, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 50,816,585	$ 51,177,250
Due after one year through five years	186,280,459	194,684,397
Due after five years through ten years	122,804,652	125,264,726
Due after ten years	61,663,132	64,019,614
Mortgage and asset-backed securities	30,470,248	33,491,460
	$ 452,035,075	$ 468,637,447

The detail of realized gains (losses) of bonds for the years ended December 31, 2020 and 2019 were as follows:

	2020	2019
Gross realized gains	$ 263,816	$ 260,773
Gross realized losses	(58,284)	(83,852)
Net realized gains	$ 205,532	$ 176,921

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

	2020					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ -	$ -	$ -	$ -
States, territories and possessions	14,231,989	(76,568)	-	-	14,231,989	(76,568)
Political subdivisions of states, territories and possessions	1,195,654	(2,058)	-	-	1,195,654	(2,058)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	23,533,732	(96,151)	-	-	23,533,732	(96,151)
Industrial and misc.	-	-	-	-	-	-
Total invested assets	$ 38,961,375	$ (174,777)	$ -	$ -	$ 38,961,375	$ (174,777)

	2019					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ 2,091,701	$ (27,067)	$ 2,091,701	$ (27,067)
States, territories and possessions	-	-	487,227	(810)	487,227	(810)
Political subdivisions of states, territories and possessions	2,889,067	(56,292)	2,377,163	(2,155)	5,266,230	(58,447)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	9,828,982	(81,419)	19,627,549	(111,455)	29,456,531	(192,874)
Industrial and misc.	-	-	20,896,697	(113,937)	20,896,697	(113,937)
Total invested assets	$ 12,718,049	$ (137,711)	$ 45,480,337	$ (255,424)	$ 58,198,386	$ (393,135)

The unrealized loss from all debt securities was generated from 16 investment positions at December 31, 2020. All issuers of debt securities the Company owns that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, the Company did not intend to sell any debt securities with an unrealized loss position, and it is not likely that the Company will be required to sell these debt securities before recovery of their amortized cost basis. As a result, the Company believes that the debt securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2020.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2020 and 2019 were as follows:

	2020		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 6,584,820	$ -	$ 6,584,820
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	6,584,820	-	6,584,820
Deferred tax assets nonadmitted	(172,075)	-	(172,075)
Subtotal net admitted deferred tax assets	6,412,745	-	6,412,745
Gross deferred tax liabilities	(188,769)	-	(188,769)
Net admitted deferred tax asset/(liability)	$ 6,223,976	$ -	$ 6,223,976

	2019		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 4,595,881	$ -	$ 4,595,881
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	4,595,881	-	4,595,881
Deferred tax assets nonadmitted	(140,442)	-	(140,442)
Subtotal net admitted deferred tax assets	4,455,439	-	4,455,439
Gross deferred tax liabilities	(209,744)	-	(209,744)
Net admitted deferred tax asset/(liability)	$ 4,245,695	$ -	$ 4,245,695

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2020 and 2019 were as follows:

	December 31, 2020		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 6,072,260	$ -	$ 6,072,260
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	151,716	-	151,716
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	151,716
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	50,818,910
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	188,769	-	188,769
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 6,412,745	$ -	$ 6,412,745

	December 31, 2019		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 4,186,108	$ -	$ 4,186,108
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	59,587	-	59,587
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	59,587
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	41,308,374
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	209,744	-	209,744
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 4,455,439	$ -	$ 4,455,439

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2020	2019
Ratio percentage used to determine recovery period and threshold limitation amount	460%	422%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 338,792,733	$ 275,389,161

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2020 and 2019 consisted of the following:

	2020	2019
Current year income tax provision	$ 36,707,753	$ 20,634,286
Revisions in prior years' estimated taxes	1,861	(31,003)
Federal income tax expense excluding the tax on realized capital (losses) gains and before change in net deferred income taxes	36,709,614	20,603,283
Tax on realized capital (losses) gains	458,917	37,154
Change in net deferred income taxes	(2,009,914)	(1,202,134)
Total statutory income taxes	$ 35,158,617	$ 19,438,303

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2020 and 2019 were as follows:

	2020	2019	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 3,829,727	$ 3,188,518	$ 641,209
Advance premiums	286,112	212,465	73,647
Policyholder reserves	-	-	-
Investments	-	-	-
Deferred acquisition costs	300,071	251,320	48,751
Policyholder dividends accrual	-	-	-
Fixed assets	213,522	243,601	(30,079)
Compensation and benefit accruals	-	-	-
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	-	-	-
Bad debts	1,137,360	63,723	1,073,637
Accrued litigation	-	-	-
CMS Rx reserves	626,165	306,097	320,068
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	172,311	296,132	(123,821)
Accrued lease	-	4,696	(4,696)
Section 197 intangibles	19,552	29,329	(9,777)
Reinsurance fee	-	-	-
Provider contracts	-	-	-
Premium acquisition expense	-	-	-
Gross ordinary DTAs	6,584,820	4,595,881	1,988,939
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(172,075)	(140,442)	(31,633)
Admitted ordinary DTAs	6,412,745	4,455,439	1,957,306
Capital			
Investments	-	-	-
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	-	-	-
Statutory valuation allowance adjustment	-	-	-
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 6,412,745	$ 4,455,439	$ 1,957,306

	2020	2019	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	-	-	-
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(3,916)	(5,777)	1,861
CMS Rx reserve	-	-	-
Reserve transition adjustment	(169,973)	(203,967)	33,994
Accrued lease	(14,880)	-	(14,880)
Ordinary DTLs	(188,769)	(209,744)	20,975
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(188,769)	(209,744)	20,975
Net deferred tax assets/(liabilities)	$ 6,223,976	$ 4,245,695	$ 1,978,281

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from.

The change in nonadmitted deferred tax assets from December 31, 2019 to 2020 was an increase of $31,633. The change in nonadmitted deferred tax assets from December 31, 2018 to 2019 was an increase of $60,612.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the HCRL fee, change to nonadmitted assets and deferred tax true-ups and tax-exempt interest in 2020.

The Company had no net operating loss carryforwards at December 31, 2020 or 2019.

The following table demonstrates the income tax expense for 2019 and 2020 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2019	$ 20,636,147	$ 37,154	$ 20,673,301
2020	36,707,753	458,917	37,166,670
	$ 57,343,900	$ 496,071	$ 57,839,971

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2020 or 2019.

As of December 31, 2020, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2017 and prior years. Humana's 2018 and 2019 tax returns are in the post-filing review period under the Compliance Assurance Process (CAP). Humana's 2020 tax return is under advance review by the IRS under CAP. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2020 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2020
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	ARCADIAN HEALTH PLAN, INC.	20-1001348
6	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
7	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
8	CARENETWORK, INC.	39-1514846
9	CAREPLUS HEALTH PLANS, INC.	59-2598550
10	CARITEN HEALTH PLAN INC.	62-1579044
11	CHA HMO, INC.	61-1279717
12	COMPBENEFITS COMPANY	59-2531815
13	COMPBENEFITS CORPORATION	04-3185995
14	COMPBENEFITS DENTAL, INC.	36-3686002

15	COMPBENEFITS DIRECT, INC.	58-2228851
16	COMPBENEFITS INSURANCE COMPANY	74-2552026
17	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
18	CONTINUCARE CORPORATION	59-2716023
19	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
20	CONVIVA HEALTH MANAGEMENT, LLC (f/k/a TRANSCEND POPULATION HEALTH MANAGEMENT, LLC)	46-5329373
21	CONVIVA HEALTH MSO OF TEXAS, INC. (f/k/a PRIMARY CARE HOLDINGS, INC.)	46-1225873
22	CONVIVA MEDICAL CENTER MANAGEMENT OF TEXAS, P.A. (f/k/a PARTNERS IN PRIMARY CARE, P.A.)	47-1161014
23	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
24	DENTICARE, INC.	76-0039628
25	EAGLE RX HOLDCO, INC.	47-1407967
26	EAGLE RX, INC.	47-1416614
27	EDGE HEALTH MSO, INC.	84-2214810
28	EDGE HEALTH, P.C.	84-2752906
29	EMPHESYS INSURANCE COMPANY	31-0935772
30	EMPHESYS, INC.	61-1237697
31	ENCLARA PHARMACIA, INC.	23-3068914
32	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
33	FPG ACQUISITION CORP.	81-3802918
34	FPG ACQUISITION HOLDINGS CORP.	81-3819187
35	FPG HOLDING COMPANY, LLC	32-0505460
36	GUIDANTRX, INC.	39-1789830
37	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291
38	HEALTH VALUE MANAGEMENT, INC.	61-1223418
39	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
40	HUMANA AT HOME (DALLAS), INC.	75-2739333
41	HUMANA AT HOME (HOUSTON), INC.	76-0537878
42	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
43	HUMANA AT HOME (TLC), INC.	75-2600512
44	HUMANA AT HOME 1, INC.	65-0274594
45	HUMANA AT HOME, INC.	13-4036798
46	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
47	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
48	HUMANA BENEFIT PLAN OF TEXAS, INC.	75-2043865
49	HUMANA DENTAL COMPANY	59-1843760
50	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC.	80-0072760
51	HUMANA DIRECT CONTRACTING ENTITY, INC.	85-3099097
52	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
53	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
54	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
55	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
56	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
57	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
58	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
59	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
60	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632

61	HUMANA HEALTH PLAN, INC.	61-1013183
62	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
63	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
64	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
65	HUMANA INSURANCE COMPANY	39-1263473
66	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
67	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
68	HUMANA MARKETPOINT, INC.	61-1343508
69	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
70	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
71	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
72	HUMANA MEDICAL PLAN, INC.	61-1103898
73	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
74	HUMANA PHARMACY, INC.	61-1316926
75	HUMANA REAL ESTATE COMPANY	20-1724127
76	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
77	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
78	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
79	HUMANADENTAL INSURANCE COMPANY	39-0714280
80	HUMANADENTAL, INC.	61-1364005
81	HUMCO, INC.	61-1239538
82	HUM-e-FL, INC.	61-1383567
83	MANAGED CARE INDEMNITY, INC.	61-1232669
84	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
85	METCARE OF FLORIDA, INC.	65-0879131
86	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
87	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
88	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
89	PARTNERS IN PRIMARY CARE (KS), P.A.	30-1236218
90	PARTNERS IN PRIMARY CARE (KS), P.C.	85-0733589
91	PARTNERS IN PRIMARY CARE (MO), P.C.	85-3676937
92	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
93	PARTNERS IN PRIMARY CARE (SC), P.C.	85-3577914
94	PBM HOLDING COMPANY	61-1340806
95	PBM PLUS MAIL SERVICE PHARMACY, LLC	20-2373204
96	PHP COMPANIES, INC.	62-1552091
97	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
98	PRIMARY CARE MANAGEMENT, INC.	85-0858631
99	ROHC, LLC	75-2844854
100	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
101	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
102	TEXAS DENTAL PLANS, INC.	74-2352809
103	THE DENTAL CONCERN, INC.	52-1157181
104	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
105	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
106	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105

5. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2020 and 2019 are summarized as follows:

	2020	2019
Balance at January 1,	$ 210,151,227	$ 171,420,855
Health care receivables	(32,724,392)	(30,815,294)
Balance at January 1, net of health care receivables	177,426,835	140,605,561
Benefits incurred and loss adjustment expenses related to		
Current year	2,181,165,902	1,972,934,198
Prior year	(7,552,606)	(5,600,158)
	2,173,613,296	1,967,334,040
Benefits and loss adjustment expenses paid related to		
Current year	1,943,940,496	1,800,742,299
Prior year	168,134,948	129,770,467
	2,112,075,444	1,930,512,766
Balance at December 31,	282,873,684	210,151,227
Health care receivables	(43,908,997)	(32,724,392)
Balance at December 31, net of health care receivables	$ 238,964,687	$ 177,426,835

Benefits and loss adjustment expenses payable, net of healthcare receivables, as of December 31, 2019 were $177,426,835. As of December 31, 2020, $168,134,948 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $1,739,281 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $7,552,606 favorable prior-year development since December 31, 2019. The decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included in this decrease, the Company experienced $14,539,521 of favorable prior year claim development on retrospectively rated policies. However, the business to which it relates is subject to premium adjustments.

6. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the Department statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the Department is the lesser of 10% of total surplus, or the greater of net operating gain for the calendar year preceding the dividend or for the 3 calendar years preceding the dividend less dividends paid for the most recent 2 of those calendar years. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $27,960,000 in 2020 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the Department.

		Dividend or Return of Capital Amount		
		Ordinary	Extraordinary	Date Paid
Dividend		$ 27,500,000	$ -	May 26, 2020
	Total paid in 2020	$ 27,500,000	$ -	
Dividend		$ 25,280,000	$ 24,720,000	April 30, 2019
	Total paid in 2019	$ 25,280,000	$ 24,720,000	

7. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Louisiana has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $73,617,376 or the Company, under the discretion of the Commissioner of the Department, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Louisiana which require a minimum capital and surplus level of $147,234,752 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $345,088,902 and $279,634,856 as of December 31, 2020 and 2019, respectively.

8. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $185,997 and $264,508 for the years ended December 31, 2020 and 2019, respectively.

Employees supporting the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2020 and 2019 total allocated expenses associated with these plans were $3,104,018 and $2,379,744, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2020 and 2019 were $274,700,933 and $222,278,616, respectively, which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 4, which were $47,929,458 and $23,875,644 for the years ended December 31, 2020 and 2019, respectively. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $8,188,052 and $16,197,204 due from Humana at December 31, 2020 and 2019, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

In the ordinary course of business, the Company also directly contracts with related parties to provide services that are routine in nature to its members. The administrative services, access fees, and cost of care services provided are determined within each individual agreement. These amounts are included in benefits incurred and loss adjustment expenses as well as selling, general and administrative expenses in the statutory statements of revenue and expenses.

The following table identifies the amount for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2020 and 2019, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliate and Other Related Parties* (SSAP No. 25):

		2020		2019
SeniorBridge and Humana At Home	$	20,500,557	$	18,409,488
PMR Virginia Holding LLC (JenCare)		32,755,157		-
Total	$	53,255,714	$	18,409,488

In addition to the related parties above, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(k) for further consideration of related pharmacy rebates. The Company had $713,336,737 and $588,521,643 of administrative service and prescription costs in 2020 and 2019, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(i).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $224,577,725 and $180,810,672 of prescription costs in 2020 and 2019, respectively, with Humana Pharmacy, Inc.

The Company received no capital contributions in the years ended December 31, 2020 or 2019.

Humana forgave $640,194 of the Company's tax liability due to Humana as part of the Company's tax sharing agreement during 2019. The portion of the tax balance being forgiven is associated with an issue that was previously subject to IRS Appeals. The forgiveness was accounted for as contributed surplus per SSAP No. 72 *Surplus and Quasi-Reorganizations* (SSAP No. 72).

9. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to four years. Operating lease rental payments charged to expenses for the years ended December 31, 2020 and 2019 was $1,502,726 and $1,437,327, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

Future minimum rental payments required under operating leases as of December 31, 2020, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2021	$	1,283,357
2022		1,101,548
2023		1,112,675
2024		1,112,675
2025		-
Thereafter		-
Total minimum lease payments	$	4,610,255

10. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $2,214,734,297 and $1,891,053,121 for the years ended December 31, 2020 and 2019, respectively. The loss of the Contracts (which are generally renewed annually) or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2021, and all product offerings filed with CMS for 2021 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the BBA and BIPA, generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers

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

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

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for the payment years 2015 and 2014. CMS completed its RADV contract level audit of the 2012 payment year, but has not yet provided the results.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2016. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus or cash flows.

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

capricious in departing from CMS's RADV methodology without adequate explanation (among other reasons). CMS has appealed the decision to the Circuit Court of Appeals.

The Company will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

b. **COVID-19:** The emergence and spread of the novel coronavirus, or COVID-19, has impacted the Company's business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020 and continued to rebound throughout the third quarter and early in the fourth quarter of 2020. Then, in the latter half of November and accelerating throughout the month of December, the Company experienced a significant increase in COVID-19 admissions in nearly all of the markets in which it operates across the Company's lines of business resulting in higher COVID-19 treatment and testing costs. During this period, the Company also experienced a corresponding decline in non-COVID utilization in all service categories. The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during the period. The Company's 2020 results were also impacted by ongoing pandemic relief efforts.

c. **Legal Proceedings:** During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus and cash flows, and may also affect the Company's reputation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided Humana's legal counsel with an information request concerning Humana's Medicare Part C risk adjustment practices. The request relates to Humana's oversight and submission of risk adjustment data generated by providers in its MA network, as well as to its business and compliance practices related to risk adjustment data generated by its providers and by Humana, including medical record reviews conducted as part of its data and payment accuracy compliance

efforts, the use of health and well-being assessments, and fraud detection efforts. Humana believes that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of MA plans, providers and vendors. Humana continues to cooperate with the Department of Justice. These matters are expected to result in additional qui tam litigation.

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

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. Securities & Credit Markets Risks: Ongoing volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or credit related impairments may be recorded in future periods.

Supplemental Investment Information

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

Of the **Humana Health Benefit Plan of Louisiana, Inc.** Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436

NAIC Group Code 0119 NAIC Company Code 95642 Employer's ID Number 72-1279235

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $674,252,399.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	State Of Louisiana	Municipal	$ 123,803,713	18.36%
2.02	Federal Farm Credit Banks Funding Corporation	Bonds	30,489,107	4.52%
2.03	Federal National Mortgage Association	MBS CMO	23,928,633	3.55%
2.04	Federal Home Loan Banks	Bonds	22,855,000	3.39%
2.05	Apple Inc.	Bonds Commercial Paper	14,504,161	2.15%
2.06	Bossier Parish Schools	Municipal	14,424,241	2.14%
2.07	City of New Orleans	Municipal	14,228,277	2.11%
2.08	East Baton Rouge Louisiana Sewerage Commission	Municipal	10,810,408	1.60%
2.09	Shreveport Louisiana	Municipal	9,863,474	1.46%
2.10	Entergy Louisiana LLC	Bonds	8,826,151	1.31%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 477,811,242	70.87%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	48,714,062	7.22%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	1,506,984	0.22%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	1,999,763	0.30%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	-	0.00%	3.12	P/RP-6	-	0.00%

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [X]	No [ ]
4.02	Total admitted assets held in foreign investments.	$	-	0.00%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	-	0.00%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
6.01	Country:	$	-	0.00%
6.02	Country:		-	0.00%
	Countries rated NAIC - 2			
6.03	Country:	$	-	0.00%
6.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
6.05	Country:	$	-	0.00%
6.06	Country:		-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1 Issuer	2 NAIC Rating	3	4
10.01			$ -	0.00%
10.02			-	0.00%
10.03			-	0.00%
10.04			-	0.00%
10.05			-	0.00%
10.06			-	0.00%
10.07			-	0.00%
10.08			-	0.00%
10.09			-	0.00%
10.10			-	0.00%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.			
11.02	Total admitted assets held in Canadian Investments	$	-	0.00%
11.03	Canadian-currency-denominated investments		-	0.00%
11.04	Canadian-denominated insurance liabilities		-	0.00%
11.05	Unhedged Canadian currency exposure		-	0.00%

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ -	0.00%
	Largest 3 investments with contractual sales restrictions		
12.03		-	0.00%
12.04		-	0.00%
12.05		-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1	2	3
	Name of Issuer		
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	JPMorgan Trust II - JPMorgan U.S. Treasury Plus Money Market Fund	$ 41,115,747	$ 41,115,747	$ -
14.07		-	-	-
14.08		-	-	-
14.09		-	-	-
14.10		-	-	-
14.11		-	-	-
14.12		-	-	-
14.13		-	-	-
14.14		-	-	-
14.15		-	-	-

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1	2	3
	Type (Residential, Commercial, Agricultural)		
16.02		$ -	0.00%
16.03		-	0.00%
16.04		-	0.00%
16.05		-	0.00%
16.06		-	0.00%
16.07		-	0.00%
16.08		-	0.00%
16.09		-	0.00%
16.10		-	0.00%
16.11		-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description		
	1	2	3
18.02		$ -	0.00%
18.03		-	0.00%
18.04		-	0.00%
18.05		-	0.00%
18.06		-	0.00%

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:	**2**	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	-	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2020

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1 Amount	2 Percentage	1 Amount	2 Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 5,224,149	0.91%	$ 5,224,149	0.91%
1.02	All other governments	-	0.00%	-	0.00%
1.03	U.S. states, territories and possessions, etc. guaranteed	103,208,147	18.07%	103,208,147	18.07%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	59,321,801	10.38%	59,321,801	10.38%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	152,946,563	26.77%	152,946,563	26.77%
1.06	Industrial and miscellaneous	131,334,416	22.99%	131,334,416	22.99%
1.07	Hybrid securities	-	0.00%	-	0.00%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	452,035,075	79.13%	452,035,075	79.13%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	-	0.00%	-	0.00%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	-	0.00%	-	0.00%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	-	0.00%	-	0.00%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	-	0.00%	-	0.00%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total valuation allowance	-	0.00%	-	0.00%
4.06	Total mortgage loans	-	0.00%	-	0.00%
5. Real estate					
5.01	Properties occupied by company	-	0.00%	-	0.00%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	-	0.00%	-	0.00%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	69,140	0.01%	69,140	0.01%
6.02	Cash equivalents	119,112,724	20.85%	119,112,724	20.85%
6.03	Short-term investments	-	0.00%	-	0.00%
6.04	Total cash, cash equivalents and short-term investments	119,181,864	20.86%	119,181,864	20.86%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		-	0.00%	-	0.00%
10. Receivables for securities		16,750	0.00%	16,750	0.00%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 571,233,689	100.00%	$ 571,233,689	100.00%

Humana Health Benefit Plan of Louisiana, Inc.

(a wholly owned subsidiary of Humana Insurance Company, a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2021 and 2020

Humana Health Benefit Plan of Louisiana, Inc.
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Statutory Basis of Accounting
December 31, 2021 and 2020

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Report of Independent Auditors

To the Board of Directors of Humana Health Benefit Plan of Louisiana Inc.

Opinions

We have audited the accompanying statutory financial statements of Humana Health Benefit Plan of Louisiana, Inc. (the "Company"), which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2021 and 2020, and the related statutory statements of revenue and expenses, of changes in surplus, and of cash flows for the years then ended, including the related notes (collectively referred to as the "financial statements").

Unmodified Opinion on Statutory Basis of Accounting

In our opinion, the accompanying financial statements present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Louisiana Department of Insurance described in Note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the accompanying financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2021 and 2020, or the results of its operations or its cash flows for the years then ended.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Louisiana Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Louisiana Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the financial statements taken as a whole. The supplemental summary investment schedule and schedule of investment risk interrogatories (collectively referred to as the "supplemental schedules") of the Company as of December 31, 2021 and for the year then ended are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 20, 2022

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2021 and 2020

	2021	2020
Admitted Assets		
Cash and invested assets		
Bonds	$ 471,026,146	$ 452,035,075
Receivable for securities	13,541	16,750
Total invested assets	471,039,687	452,051,825
Cash	(5,431,684)	69,140
Cash equivalents	94,981,596	119,112,724
Total cash and invested assets	560,589,599	571,233,689
Premiums receivable	42,127,433	32,786,060
Investment income due and accrued	3,757,533	4,067,856
Amounts receivable relating to uninsured plans	17,388,575	11,293,207
Health care and other receivables	80,834,945	39,667,833
Net deferred tax assets	5,609,860	6,223,976
Electronic data processing equipment and software, less accumulated depreciation of $24,064 and $4,813 in 2021 and 2020, respectively	52,942	72,193
Furniture and equipment, less accumulated depreciation of $992,004 and $842,812 in 2021 and 2020, respectively	595,636	719,533
Receivable from Humana Inc.	22,472,327	8,188,052
Total admitted assets	$ 733,428,850	$ 674,252,399
Liabilities		
Benefits and loss adjustment expenses payable	$ 286,576,520	$ 282,873,684
Aggregate health policy reserves	29,342,426	22,651,755
Aggregate health claim reserves	61,399	236,869
Advance premiums	9,376,890	6,807,644
Accounts payable and accrued expenses	28,224,760	15,655,093
Current federal income tax payable	8,930,317	938,452
Total liabilities	362,512,312	329,163,497
Surplus		
Common stock, $0 par value; $1 per share stated value; 1,000 shares authorized; 1,000 shares issued and outstanding	1,000	1,000
Paid-in surplus	66,400,346	66,400,346
Unassigned surplus	304,515,192	278,687,556
Total surplus	370,916,538	345,088,902
Total liabilities and surplus	$ 733,428,850	$ 674,252,399

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2021 and 2020

	2021	2020
Earned premiums	$ 2,893,456,138	$ 2,582,581,489
Expenses		
Benefits incurred and loss adjustment expenses	2,518,758,009	2,173,613,296
Selling, general and administrative expenses	221,411,460	281,412,042
Changes in aggregate health policy reserves	1,774,529	1,950,870
Total expenses	2,741,943,998	2,456,976,208
Net underwriting gain	151,512,140	125,605,281
Net investment income	9,100,862	10,682,504
Net realized capital losses on investments (net of capital gains tax of $111,085 and $458,917, respectively)	(110,073)	(253,385)
Net other income	64,688	64,828
Income before federal income tax expense	160,567,617	136,099,228
Federal income tax expense	32,527,702	36,709,614
Net income	$ 128,039,915	$ 99,389,614

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2021 and 2020

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2020	1,000	$ 1,000	$ 44,204,567	$ 66,400,346	$ 169,028,943	$ 279,634,856
Net income	-	-	-	-	99,389,614	99,389,614
HCRL fee moratorium	-	-	(44,204,567)	-	44,204,567	-
Change in net deferred income taxes	-	-	-	-	2,009,914	2,009,914
Change in nonadmitted assets	-	-	-	-	(8,445,482)	(8,445,482)
Dividends or return of capital paid	-	-	-	-	(27,500,000)	(27,500,000)
Balances at December 31, 2020	1,000	1,000	-	66,400,346	278,687,556	345,088,902
Net income	-	-	-	-	128,039,915	128,039,915
Change in net deferred income taxes	-	-	-	-	(291,272)	(291,272)
Change in nonadmitted assets	-	-	-	-	(1,921,007)	(1,921,007)
Dividends or return of capital paid	-	-	-	-	(100,000,000)	(100,000,000)
Balances at December 31, 2021	1,000	$ 1,000	$ -	$ 66,400,346	$ 304,515,192	$ 370,916,538

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Health Benefit Plan of Louisiana, Inc.
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2021 and 2020

	2021	2020
Cash flows from operations		
Premiums collected	$ 2,892,004,165	$ 2,584,551,650
Net investment income received	14,055,449	14,787,237
Benefits paid	(2,418,715,282)	(2,029,002,548)
Selling, general and administrative expenses paid	(339,601,137)	(362,554,924)
Federal income taxes paid	(24,646,922)	(39,649,804)
Net cash from operations	123,096,273	168,131,611
Cash flows from investments		
Proceeds from investments sold or matured	96,134,572	137,285,072
Cost of investments acquired	(104,766,602)	(188,620,151)
Net cash used for investments	(8,632,030)	(51,335,079)
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(100,000,000)	(27,500,000)
Other cash (applied) provided	(44,096,195)	5,082,442
Net cash used for financing and miscellaneous sources	(144,096,195)	(22,417,558)
Net change in cash and cash equivalents	(29,631,952)	94,378,974
Cash and cash equivalents		
Beginning of year	119,181,864	24,802,890
End of year	$ 89,549,912	$ 119,181,864

The accompanying notes are an integral part of these statutory basis financial statements.

1. Reporting Entity

Humana Health Benefit Plan of Louisiana, Inc. (the Company), a wholly owned subsidiary of Humana Insurance Company (HIC), a wholly owned subsidiary of CareNetwork, Inc. (CNI), a wholly owned subsidiary of Humana Inc. (Humana), is a health maintenance organization (HMO) domiciled in the state of Louisiana and is authorized to sell health plan products therein. The Company is subject to regulation by the federal government and the Louisiana Department of Insurance (the Department). State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 7, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 6.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 10(a).

As part of the Company's individual Medicare Advantage products, it also offers Dual Eligible Special Needs (D-SNP) plans. In connection with offering a D-SNP plan in a particular state, the Company is required to enter into a special coordinating contract with the applicable state Medicaid agency.

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the Department, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(m), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Comprehensive income disclosures required by GAAP are omitted; and

viii. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

ix. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The Department adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The Department has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. The Commissioner of Insurance of the State of Louisiana allows the Company to admit its furniture and equipment used for Health Maintenance Organization operations, which is not in accordance with NAIC SSAP. The omission of this prescribed practice would have had no impact to the results of the Company's risk-based capital calculations.

The statutory financial statements of the Company are presented on the basis of accounting practices prescribed or permitted by the Department. A reconciliation of the Company's net income and surplus based on practices prescribed by the Department to net income and surplus based on Codification at December 31, 2021 and 2020 is shown below:

	2021	2020
Net Income – State of Louisiana basis	$ 128,039,915	$ 99,389,614
State prescribed or permitted practices	-	-
Net Income – Codification	$ 128,039,915	$ 99,389,614
Surplus – State of Louisiana basis	$ 370,916,538	$ 345,088,902
State prescribed or permitted practices		
a. Furniture and equipment	(595,636)	(719,533)
Surplus – Codification	$ 370,320,902	$ 344,369,369

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage (MA) premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases the Company's effective tax rate, was in effect for calendar year 2020 and permanently repealed beginning in calendar year 2021. The annual health insurance industry fee levied on the insurance industry was $15.5 billion in 2020.

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

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, create

uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. Cash and Cash Equivalents: The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies,

failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds, cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2021 or December 31, 2020.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2021 or 2020.

For other restricted assets reported in aggregate, the pledged amounts with the Department were $500,000 and $1,250,000, which is 0.07% and 0.18% of gross assets and 0.07% and 0.19% of net admitted assets, at December 31, 2021 and 2020, respectively. These investments, generally certificates of deposit, were on deposit at December 31, 2021 and 2020 to satisfy requirements of regulatory agencies. These assets are included in cash in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

e. Fair Value: In accordance with SSAP No. 100R, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. Fair value of privately held investment grade debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held investment grade debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business with similar credit characteristics, and reviewing the underlying financial performance including estimating discounted cash flows. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2021 or 2020.

The Company did not have any financial assets carried at fair value in the accompanying statements of admitted assets, liabilities, and surplus as of December 31, 2021 and 2020.

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2021 and 2020 were as follows:

	December 31, 2021					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and cash equivalents	$ 570,986,122	$ 566,007,742	$ 14,999,083	$ 555,987,039	$ -	$ -

	December 31, 2020					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds and cash equivalents	$ 587,750,171	$ 571,147,799	$ 77,996,977	$ 509,753,194	$ -	$ -

f. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other income (expense) in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from 3 to 10 years. Depreciation expense, including that related to the nonadmitted portion, was $168,443 and $146,548 for the years ended December 31, 2021 and 2020, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements, including that related to the nonadmitted portion, was $185,767 and $182,351 for the years ended December 31, 2021 and 2020, respectively.

g. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross

deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2021 and 2020 DTAs of $494,919 and $172,075, respectively, were nonadmitted.

h. Earned Premiums: Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for its membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022.

The amount of net premiums written by the Company in 2021 and 2020 that were subject to retrospective rating features were $2,817,163,558 and $2,505,288,743, respectively, or 97.36%

and 97.01%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $33,262,805 and $23,096,271 as of December 31, 2021 and 2020, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company did not have any rebates incurred, paid or unpaid as of December 31, 2021 and 2020.

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

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets,

liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. The 2020 settlement with CMS did not occur in the current year.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2021 and 2020:

	2021		2020	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 1,724,495	$ -	$ 3,403,311	$ -
Amounts receivable relating to uninsured plans	-	17,388,575	-	11,293,207
Aggregate health policy reserves	(5,569,263)	-	(2,140,108)	-
Accounts payable and accrued expenses	-	(8,347,085)	-	(10,094,972)
Net (liability) asset	$ (3,844,768)	$ 9,041,490	$ 1,263,203	$ 1,198,235

j. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire

subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company risk adjustment data for 2018 and 2019 was selected for audit by HHS. The final assessment from this audit was immaterial to the statutory statements of revenues and expenses.

The temporary risk corridor program applied to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including the Company's small group health plans, were not subject to the risk corridor program. The risk corridor provisions were included to limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to the Company or require it to refund HHS a portion of the premiums the Company received.

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2021 and 2020:

HCRL Risk Adjustment		
Assets	**2021**	**2020**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 3,169,950	$ 2,900,060
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	14,216	16,485
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	-	-
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	1,008,143	1,985,298
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	10,569	13,821

HCRL Risk Corridor		
Assets	**2021**	**2020**
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	-	6,513,426
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 415,970	$ -	$ 415,970	$ -	$ -	$ -
2015	3,073,968	-	3,073,968	-	-	-
2016	3,092,926	-	3,092,926	-	-	-
Total	$ 6,582,864	$ -	$ 6,582,864	$ -	$ -	$ -

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government for payments under the risk corridor premium stabilization program established under the HCRL for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, the Company received $6,513,426 from the U.S Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $6,513,426 payment received from the U.S Government and $325,573 in related fees and expenses are reflected in net premium income and selling, general and administrative expenses, respectively.

The transitional reinsurance program required the Company to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial

medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the HCRL in the individual commercial market were eligible for recoveries if individual claims exceed a specified threshold. Accordingly, the Company accounted for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in its statutory statements of revenue and expenses. The Company accounted for contributions made by individual commercial plans compliant with the HCRL, which were subject to recoveries, as ceded premiums (a reduction of earned premiums) and similarly the Company accounted for any recoveries as ceded benefits (a reduction of benefits incurred and loss adjustment expenses) in its statutory statements of revenue and expenses.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses does not include any amounts associated with the transitional HCRL reinsurance program as of December 31, 2021 and 2020.

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	2,900,060		885,603		2,014,457		972,529		A.	2,986,986	
2. Premium adjustments (payables) (including high risk pool payments)		-		(147,350)		147,350		(147,350)	B.		-
3. Subtotal ACA Permanent Risk Adjustment Program	2,900,060	-	885,603	(147,350)	2,014,457	147,350	972,529	(147,350)		2,986,986	-
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		-		-		-			-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	

4. Liabilities for contributions payable due to ACA Reinsurance- not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		-		-		-			-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk Sharing Provisions	2,900,060	-	885,603	(147,350)	2,014,457	147,350	972,529	(147,350)		2,986,986	-

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2020 benefit year and the latest data from Wakely Consulting.

B. Adjustments related to updates received from CMS associated with 2020 benefit year and the latest data from Wakely Consulting.

Net collections under the 3Rs associated with prior coverage years were $738,253 and $5,754,498 in 2021 and 2020, respectively.

k. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 8. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2021, 2020, and 2019:

Quarter	Estimate Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days after Billing
12/31/2021	$ 57,704,002	$ 57,704,002	$ -	$ -	$ -
9/30/2021	60,034,354	59,908,331	59,113,586	-	-
6/30/2021	70,165,369	71,843,133	71,394,734	-	-
3/31/2021	58,245,572	53,467,845	53,335,631	-	45,511
12/31/2020	38,575,173	38,575,173	38,531,083	-	36,273
9/30/2020	51,140,722	51,140,722	50,802,132	284,171	54,419
6/30/2020	55,826,262	55,826,262	55,355,084	346,063	125,115
3/31/2020	44,038,822	44,038,822	43,108,835	883,660	44,031
12/31/2019	32,409,099	32,409,099	32,211,775	-	197,324
9/30/2019	37,222,346	37,222,346	36,963,112	72,501	186,733
6/30/2019	56,554,808	56,554,808	55,832,379	219,447	502,982
3/31/2019	39,411,645	39,411,645	39,018,971	-	392,674

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $1,339,960 and $806,424 were nonadmitted at December 31, 2021 and 2020, respectively.

l. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. The Company's reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for

IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $5,827,000 and $3,877,001 at December 31, 2021 and 2020, respectively, which are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

m. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

n. Going Concern Considerations: Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

o. Subsequent Events: The Company evaluated subsequent events through April 20, 2022, the date these financial statements were issued or available to be issued.

The Company is not aware of any events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements, which may have a material effect on its financial condition.

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2021 and 2020 were as follows:

	2021			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 3,468,343	$ 88,686	$ (5,358)	$ 3,551,671
All other governments	-	-	-	-
States, territories and possessions	98,387,515	1,854,989	(493,231)	99,749,273
Political subdivisions of states, territories and possessions	54,178,101	1,748,539	(147,772)	55,778,868
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	190,686,607	2,769,703	(2,564,132)	190,892,178
Industrial and miscellaneous	124,305,580	2,631,869	(904,913)	126,032,536
Hybrid securities	-	-	-	-
Total bonds	$ 471,026,146	$ 9,093,786	$ (4,115,406)	$ 476,004,526

	2020			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 5,224,148	$ 280,716	$ -	$ 5,504,864
All other governments	-	-	-	-
States, territories and possessions	103,208,147	3,255,090	(76,568)	106,386,669
Political subdivisions of states, territories and possessions	59,321,801	2,356,543	(2,058)	61,676,286
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	152,946,563	5,018,986	(96,151)	157,869,398
Industrial and miscellaneous	131,334,416	5,865,814	-	137,200,230
Hybrid securities	-	-	-	-
Total bonds	$ 452,035,075	$ 16,777,149	$ (174,777)	$ 468,637,447

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2021, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 69,556,617	$ 70,239,071
Due after one year through five years	168,816,852	172,418,513
Due after five years through ten years	156,990,822	154,785,092
Due after ten years	48,129,011	49,466,487
Mortgage and asset-backed securities	27,532,844	29,095,363
	$ 471,026,146	$ 476,004,526

The detail of realized gains (losses) of bonds for the years ended December 31, 2021 and 2020 were as follows:

	2021	2020
Gross realized gains	$ 7,268	$ 263,816
Gross realized losses	(6,256)	(58,284)
Net realized gains	$ 1,012	$ 205,532

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2021 and 2020 were as follows:

	2021					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 1,203,182	$ (5,358)	$ -	$ -	$ 1,203,182	$ (5,358)
All other governments	-	-	-	-	-	-
States, territories and possessions	43,759,991	(493,231)	-	-	43,759,991	(493,231)
Political subdivisions of states, territories and possessions	6,341,723	(125,933)	596,316	(21,839)	6,938,039	(147,772)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	98,457,558	(2,105,346)	15,010,357	(458,786)	113,467,915	(2,564,132)
Industrial and misc.	42,798,468	(904,913)	-	-	42,798,468	(904,913)
Hybrid securities	-	-	-	-	-	-
Total invested assets	$ 192,560,922	$ (3,634,781)	$ 15,606,673	$ (480,625)	$ 208,167,595	$ (4,115,406)

	2020					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ -	$ -	$ -	$ -
All other governments	-	-	-	-	-	-
States, territories and possessions	14,231,989	(76,568)	-	-	14,231,989	(76,568)
Political subdivisions of states, territories and possessions	1,195,654	(2,058)	-	-	1,195,654	(2,058)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	23,533,732	(96,151)	-	-	23,533,732	(96,151)
Industrial and misc.	-	-	-	-	-	-
Hybrid securities	-	-	-	-	-	-
Total invested assets	$ 38,961,375	$ (174,777)	$ -	$ -	$ 38,961,375	$ (174,777)

The unrealized loss from all debt securities was generated from 82 investment positions at December 31, 2021. All issuers of debt securities the Company owns that were trading at an unrealized loss at December 31, 2021 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2021, the Company did not intend to sell any debt securities with an unrealized loss position, and it is not likely that the Company will be required to sell these debt securities before recovery of their amortized cost basis. As a result, the Company believes that the debt securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2021.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2021 and 2020 were as follows:

	2021		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 6,256,121	$ -	$ 6,256,121
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	6,256,121	-	6,256,121
Deferred tax assets nonadmitted	(494,919)	-	(494,919)
Subtotal net admitted deferred tax assets	5,761,202	-	5,761,202
Gross deferred tax liabilities	(151,342)	-	(151,342)
Net admitted deferred tax asset/(liability)	$ 5,609,860	$ -	$ 5,609,860

	2020		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 6,584,820	$ -	$ 6,584,820
Statutory valuation allowance adjustment	-	-	-
Adjusted gross deferred tax assets	6,584,820	-	6,584,820
Deferred tax assets nonadmitted	(172,075)	-	(172,075)
Subtotal net admitted deferred tax assets	6,412,745	-	6,412,745
Gross deferred tax liabilities	(188,769)	-	(188,769)
Net admitted deferred tax asset/(liability)	$ 6,223,976	$ -	$ 6,223,976

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2021 and 2020 were as follows:

	December 31, 2021		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 5,428,337	$ -	$ 5,428,337
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	181,523	-	181,523
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	181,523
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	54,788,060
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	151,342	-	151,342
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 5,761,202	$ -	$ 5,761,202

	December 31, 2020		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 6,072,260	$ -	$ 6,072,260
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	151,716	-	151,716
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	151,716
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	50,818,910
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	188,769	-	188,769
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 6,412,745	$ -	$ 6,412,745

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2021	2020
Ratio percentage used to determine recovery period and threshold limitation amount	441%	460%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 365,253,736	$ 338,792,733

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2021 and 2020 consisted of the following:

	2021	2020
Current year income tax provision	$ 32,529,225	$ 36,707,753
Revisions in prior years' estimated taxes	(1,523)	1,861
Federal income tax expense excluding the tax on realized capital losses and before change in net deferred income taxes	32,527,702	36,709,614
Tax on realized capital losses	111,085	458,917
Change in net deferred income taxes	291,272	(2,009,914)
Total statutory income taxes	$ 32,930,059	$ 35,158,617

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2021 and 2020 were as follows:

	2021	2020	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 3,701,156	$ 3,829,727	$ (128,571)
Advance premiums	393,379	286,112	107,267
Policyholder reserves	-	-	-
Investments	-	-	-
Deferred acquisition costs	338,894	300,071	38,823
Policyholder dividends accrual	-	-	-
Fixed assets	231,098	213,522	17,576
Compensation and benefit accruals	-	-	-
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	-	-	-
Bad debts	86,346	1,137,360	(1,051,014)
Accrued litigation	-	-	-
CMS Rx reserves	1,018,251	626,165	392,086
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	8,844	172,311	(163,467)
Accrued lease	-	-	-
Section 197 intangibles	9,776	19,552	(9,776)
Premium rebates MER	-	-	-
Provider contracts	468,377	-	468,377
Premium acquisition expense	-	-	-
Gross ordinary DTAs	6,256,121	6,584,820	(328,699)
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(494,919)	(172,075)	(322,844)
Admitted ordinary DTAs	5,761,202	6,412,745	(651,543)
Capital			
Investments	-	-	-
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	-	-	-
Statutory valuation allowance adjustment	-	-	-
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 5,761,202	$ 6,412,745	$ (651,543)

	2021	2020	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	-	-	-
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(5,439)	(3,916)	(1,523)
Bad debts	-	-	-
Reserve transition adjustment	(135,978)	(169,973)	33,995
Accrued lease	(9,925)	(14,880)	4,955
Ordinary DTLs	(151,342)	(188,769)	37,427
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(151,342)	(188,769)	37,427
Net deferred tax assets/(liabilities)	$ 5,609,860	$ 6,223,976	$ (614,116)

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from.

The change in nonadmitted deferred tax assets from December 31, 2020 to 2021 was an increase of $322,844. The change in nonadmitted deferred tax assets from December 31, 2019 to 2020 was an increase of $31,633.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to tax-exempt interest, change to nonadmitted assets and deferred tax true-ups and proration in 2021.

The Company had no net operating loss carryforwards at December 31, 2021 or 2020.

The following table demonstrates the income tax expense for 2020 and 2021 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2020	$ 36,706,230	$ 458,917	$ 37,165,147
2021	32,529,225	111,085	32,640,310
	$ 69,235,455	$ 570,002	$ 69,805,457

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2021 or 2020.

As of December 31, 2021, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2020 and prior years. Humana's 2021 tax return is under advance review by the IRS under the Compliance Assurance Process. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2021 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2021
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	ABERDEEN HOLDINGS, INC.	72-2695805
6	ABLE HOME HEALTHCARE, INC.	77-0601595
7	ADVANCED ONCOLOGY SERVICES, INC.	65-0180784
8	ALPINE HOME HEALTH CARE, LLC	36-4473376
9	AMERICAN HOMECARE MANAGEMENT CORP.	11-3306095
10	AMERICAN HOSPICE, INC.	75-2486047
11	AMICUS MEDICAL CENTER, LLC	45-4020797
12	AMICUS MEDICAL GROUP, INC.	27-3974953
13	AMICUS MEDICAL SERVICES ORGANIZATION, LLC	27-1085323
14	ARCADIAN HEALTH PLAN, INC.	20-1001348
15	ASIAN AMERICAN HOME CARE, INC.	94-3247811

16	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
17	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
18	CARENETWORK, INC.	39-1514846
19	CAREPLUS HEALTH PLANS, INC.	59-2598550
20	CARITEN HEALTH PLAN INC.	62-1579044
21	CENTERWELL CARE SOLUTIONS, INC. (f/k/a PRIMARY CARE MANAGEMENT, INC.)	85-0858631
22	CENTERWELL SENIOR PRIMARY CARE (FL), INC. (f/k/a FAMILY PHYSICIANS OF WINTER PARK, INC.)	59-3164234
23	CENTERWELL SENIOR PRIMARY CARE (KS), P.A. (f/k/a PARTNERS IN PRIMARY CARE (KS), P.A.)	30-1236218
24	CENTERWELL SENIOR PRIMARY CARE (MO), P.C. (f/k/a PARTNERS IN PRIMARY CARE (MO), P.C.)	85-3676937
25	CENTERWELL SENIOR PRIMARY CARE (NC), P.C. (f/k/a PARTNERS IN PRIMARY CARE (NC), P.C.)	82-1926920
26	CENTERWELL SENIOR PRIMARY CARE (SC), P.C. (f/k/a PARTNERS IN PRIMARY CARE (SC), P.C.)	85-3577914
27	CENTRAL ARIZONA HOME HEALTH CARE, INC.	86-0714789
28	CH SERVICES GROUP HOLDINGS, INC.	47-3061031
29	CH SERVICES HOLDINGS, INC.	47-3083265
30	CH SERVICES MIDCO HOLDINGS, INC.	47-3083393
31	CHA HMO, INC.	61-1279717
32	CHAPARRAL HOSPICE, INC.	35-2224605
33	CHARLOTTE BUYER, INC.	82-5266576
34	COMPASS HOSPICE, INC.	27-0001235
35	COMPBENEFITS COMPANY	59-2531815
36	COMPBENEFITS CORPORATION	04-3185995
37	COMPBENEFITS DENTAL, INC.	36-3686002
38	COMPBENEFITS DIRECT, INC.	58-2228851
39	COMPBENEFITS INSURANCE COMPANY	74-2552026
40	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
41	CONTINUCARE CORPORATION	59-2716023
42	CONVIVA HEALTH MANAGEMENT, LLC	46-5329373
43	CONVIVA HEALTH MSO OF TEXAS, INC.	46-1225873
44	CONVIVA MEDICAL CENTER MANAGEMENT OF TEXAS, P.A.	47-1161014
45	CURO HEALTH SERVICES HOLDINGS, INC.	27-3569032
46	CURO TEXAS HOLDINGS, LLC	46-3096415
47	CURO UTAH HOME CARE, INC.	27-3500910
48	CURO UTAH HOSPICE, INC.	27-3500790
49	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
50	DENTICARE, INC.	76-0039628
51	EAGLE RX HOLDCO, INC.	47-1407967
52	EAGLE RX, INC.	47-1416614
53	EDGE HEALTH MSO, INC.	84-2214810
54	EDGE HEALTH, P.C.	84-2752906
55	EMPHESYS INSURANCE COMPANY	31-0935772
56	EMPHESYS, INC.	61-1237697
57	ENCLARA PHARMACIA, INC.	23-3068914
58	FHI GP, INC.	75-2588220
59	FHI HEALTH SYSTEMS, INC.	75-2588219
60	FHI LP, INC.	88-0335145

61	FIRST HOME HEALTH, INC.	55-0750157
62	FOCUS CARE HEALTH RESOURCES, INC.	75-2784006
63	FPG ACQUISITION CORP.	81-3802918
64	FPG ACQUISITION HOLDINGS CORP.	81-3819187
65	FPG HOLDING COMPANY, LLC	32-0505460
66	GBA HOLDING, INC.	75-2855493
67	GENERATIONS HOSPICE SERVICE CORPORATION	42-1581419
68	GENTIVA CERTIFIED HEALTHCARE CORP.	11-2645333
69	GENTIVA HEALTH SERVICES (CERTIFIED), INC.	11-3454105
70	GENTIVA HEALTH SERVICES HOLDING CORP.	11-3454104
71	GENTIVA HEALTH SERVICES, INC.	36-4335801
72	GENTIVA SERVICES OF NEW YORK, INC.	11-2802024
73	GILBERT'S HOME HEALTH AGENCY, INC.	64-0730826
74	GIRLING HEALTH CARE SERVICES OF KNOXVILLE, INC.	62-1406895
75	GIRLING HEALTH CARE, INC.	74-2115034
76	GUIDANTRX, INC.	39-1789830
77	HARRIS, ROTHENBERG INTERNATIONAL INC.	27-1649291
78	HAWKEYE HEALTH SERVICES, INC.	42-1285486
79	HEALTH VALUE MANAGEMENT, INC.	61-1223418
80	HHS HEALTHCARE CORP.	90-0527683
81	HOME HEALTH CARE AFFILIATES OF MISSISSIPPI, INC.	62-1775256
82	HOME HEALTH CARE AFFILIATES, INC.	74-2737989
83	HOME HEALTH OF RURAL TEXAS, INC.	75-2374091
84	HOME HEALTH SERVICES, INC.	87-0494759
85	HOMECARE HOLDINGS, INC.	65-0837269
86	HORIZON HEALTH CARE SERVICES, INC.	76-0456316
87	HOSPICE FAMILY CARE, INC.	86-0710921
88	HOUSE CALL DOCTORS, INC.	20-3811538
89	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
90	HUMANA AT HOME (DALLAS), INC.	75-2739333
91	HUMANA AT HOME (HOUSTON), INC.	76-0537878
92	HUMANA AT HOME (SAN ANTONIO), INC	01-0766084
93	HUMANA AT HOME (TLC), INC.	75-2600512
94	HUMANA AT HOME 1, INC.	65-0274594
95	HUMANA AT HOME, INC.	13-4036798
96	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
97	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
98	HUMANA BENEFIT PLAN OF TEXAS, INC.	75-2043865
99	HUMANA DENTAL COMPANY	59-1843760
100	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC.	80-0072760
101	HUMANA DIRECT CONTRACTING ENTITY, INC.	85-3099097
102	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
103	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
104	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
105	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
106	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
107	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
108	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328

109	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
110	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632
111	HUMANA HEALTH PLAN, INC.	61-1013183
112	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
113	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
114	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
115	HUMANA INSURANCE COMPANY	39-1263473
116	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
117	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
118	HUMANA MARKETPOINT, INC.	61-1343508
119	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
120	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
121	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
122	HUMANA MEDICAL PLAN, INC.	61-1103898
123	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
124	HUMANA PHARMACY, INC.	61-1316926
125	HUMANA REAL ESTATE COMPANY	20-1724127
126	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
127	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
128	HUMANADENTAL INSURANCE COMPANY	39-0714280
129	HUMANADENTAL, INC.	61-1364005
130	HUMCO, INC.	61-1239538
131	HUM-E-FL, INC.	61-1383567
132	INDEPENDENT CARE HEALTH PLAN	39-1769093
133	INTEGRACARE HOLDINGS, INC.	20-8781607
134	INTEGRACARE HOME HEALTH SERVICES, INC.	75-2865632
135	INTEGRACARE INTERMEDIATE HOLDINGS, INC.	20-8781715
136	ISIDORA'S HEALTH CARE, INC.	65-1285069
137	KAH DEVELOPMENT 16, INC.	87-0548601
138	KENTUCKY HOMECARE HOLDINGS, INC.	82-3695166
139	KENTUCKY HOMECARE PARENT INC.	82-3986306
140	KSOC HOLDINGS, INC.	80-0766080
141	LOVING PEACE HOSPICE, INC.	47-1818578
142	MANAGED CARE INDEMNITY, INC.	61-1232669
143	MED. TECH. SERVICES OF SOUTH FLORIDA, INC.	65-0277280
144	MEDICAL ADVOCATE HEALTHCARE SERVICES CORPORATION	27-2932981
145	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
146	MED-TECH SERVICES OF DADE, INC.	65-1033439
147	MED-TECH SERVICES OF PALM BEACH, INC.	65-0644307
148	METCARE OF FLORIDA, INC.	65-0879131
149	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
150	MISSOURI HOME CARE OF ROLLA, INC.	43-1317147
151	NEW CENTURY HOSPICE, INC.	20-5435710
152	NEW YORK HEALTHCARE SERVICES, INC.	22-2695367
153	NURSING CARE-HOME HEALTH AGENCY, INC.	55-0633030
154	ODYSSEY HEALTHCARE HOLDING COMPANY	75-2925311
155	ODYSSEY HEALTHCARE MANAGEMENT, LP	75-2923658
156	ODYSSEY HEALTHCARE OPERATING A, LP	75-2752908

157	ODYSSEY HEALTHCARE, INC.	43-1723043
158	OHS SERVICE CORP.	22-3690699
159	PBM HOLDING COMPANY	61-1340806
160	PBM PLUS MAIL SERVICE PHARMACY, LLC	20-2373204
161	PHH ACQUISITION CORP.	20-5043135
162	PHHC ACQUISITION CORP.	38-3784032
163	PHP COMPANIES, INC.	62-1552091
164	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
165	QC-MEDI NEW YORK, INC.	11-2750425
166	QUALITY CARE - USA, INC.	11-2256479
167	REGENCY HOSPICE OF NORTHWEST FLORIDA, INC.	26-3437769
168	ROHC, L.L.C.	75-2844854
169	SENIOR HOME CARE, INC.	59-3080333
170	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
171	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
172	SHC HOLDING, INC.	42-1699530
173	SOUTHERN NEVADA HOME HEALTH CARE, INC.	87-0494757
174	SOUTHERNCARE HOLDINGS, INC.	48-1288826
175	SOUTHERNCARE, INC.	16-1645414
176	SUN BROOK HOME CARE, LLC	06-1810593
177	SYNERGY HOME CARE-ACADIANA REGION, INC.	72-1487473
178	SYNERGY HOME CARE-CAPITOL REGION, INC.	20-1376846
179	SYNERGY HOME CARE-CENTRAL REGION, INC.	36-4516940
180	SYNERGY HOME CARE-NORTHEASTERN REGION, INC.	72-1178497
181	SYNERGY HOME CARE-NORTHSHORE REGION, INC.	72-1223659
182	SYNERGY HOME CARE-NORTHWESTERN REGION, INC.	72-1431394
183	SYNERGY HOME CARE-SOUTHEASTERN REGION, INC.	72-1429305
184	SYNERGY, INC.	93-3419676
185	TEXAS DENTAL PLANS, INC.	74-2352809
186	THE AMERICAN HEARTLAND HOSPICE CORP.	43-1697602
187	THE DENTAL CONCERN, INC.	52-1157181
188	THE HOME OPTION, LLC	26-2527353
189	THE HOME TEAM OF KANSAS LLC	74-3052911
190	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
191	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
192	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105
193	US HOUSE CALL PRACTITIONERS, INC.	47-2064816
194	VAN WINKLE HOME HEALTH CARE, INC.	62-1669388
195	VOYAGER HOME HEALTH, INC.	26-1501792
196	VOYAGER HOSPICECARE, INC.	20-1173787

5. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2021 and 2020 are summarized as follows:

	2021	2020
Balance at January 1,	$ 282,873,684	$ 210,151,227
Health care receivables	(43,908,997)	(32,724,392)
Balance at January 1, net of health care receivables	238,964,687	177,426,835
Benefits incurred and loss adjustment expenses related to		
Current year	2,552,067,409	2,181,165,902
Prior year	(33,309,400)	(7,552,606)
	2,518,758,009	2,173,613,296
Benefits and loss adjustment expenses paid related to		
Current year	2,326,985,708	1,943,940,496
Prior year	201,867,989	168,134,948
	2,528,853,697	2,112,075,444
Balance at December 31,	286,576,521	282,873,684
Health care receivables	(57,707,522)	(43,908,997)
Balance at December 31, net of health care receivables	$ 228,868,999	$ 238,964,687

Benefits and loss adjustment expenses payable, net of healthcare receivables, as of December 31, 2020 were $238,964,687. As of December 31, 2021, $201,867,989 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $3,787,298 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $33,309,400 favorable prior-year development since December 31, 2020. The decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included in this decrease, the Company experienced $32,663,729 of favorable prior year claim development on retrospectively rated policies. However, the business to which it relates is subject to premium adjustments.

6. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the Department statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the Department is the lesser of 10% of total surplus, or the greater of net operating gain for the calendar year preceding the dividend or for the 3 calendar years preceding the dividend less dividends paid for the most recent 2 of those calendar years. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $34,500,000 in 2021 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the Department.

		Dividend or Return of Capital Amount		
		Ordinary	**Extraordinary**	**Date Paid**
Dividend		$ -	$ 65,500,000	April 30, 2021
Dividend		34,500,000	-	May 28, 2021
	Total paid in 2021	$ 34,500,000	$ 65,500,000	
Dividend		$ 27,500,000	$ -	May 26, 2020
	Total paid in 2020	$ 27,500,000	$ -	

7. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Louisiana has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $82,819,149 or the Company, under the discretion of the Commissioner of the Department, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Louisiana which require a minimum capital and surplus level of $165,638,298 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $370,916,538 and $345,088,902 as of December 31, 2021 and 2020, respectively.

8. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $209,094 and $185,997 for the years ended December 31, 2021 and 2020, respectively.

Employees supporting the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2021 and 2020 total allocated expenses associated with these plans were $3,178,513 and $3,104,018, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2021 and 2020 were $246,478,407 and $274,700,933, respectively, which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 4, which were $15,457,143 and $47,929,458 for the years ended December 31, 2021 and

2020, respectively. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $22,472,327 and $8,188,052 due from Humana at December 31, 2021 and 2020, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

In the ordinary course of business, the Company also directly contracts with related parties to provide services that are routine in nature to its members. The administrative services, access fees, and cost of care services provided are determined within each individual agreement. These amounts are included in benefits incurred and loss adjustment expenses as well as selling, general and administrative expenses in the statutory statements of revenue and expenses.

The following table identifies the amount for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2021 and 2020, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliate and Other Related Parties* (SSAP No. 25):

	2021	2020
SeniorBridge and Humana At Home	$ 20,525,751	$ 20,500,557
PMR Virginia Holding LLC (JenCare)	40,617,266	32,755,157
Total	$ 61,143,017	$ 53,255,714

In addition to the related parties above, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(k) for further consideration of related pharmacy rebates. The Company had $847,055,860 and $713,336,737 of administrative service and prescription costs in 2021 and 2020, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(i).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $263,798,471 and $224,577,725 of prescription costs in 2021 and 2020, respectively, with Humana Pharmacy, Inc.

The Company received no capital contributions in the years ended December 31, 2021 or 2020.

9. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to three years. Operating lease rental payments charged to expenses for the years ended December 31, 2021 and 2020 was $1,205,293 and $1,502,726,

respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

Future minimum rental payments required under operating leases as of December 31, 2021, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2022	$	1,112,360
2023		1,112,675
2024		1,112,675
2025		-
2026		-
Thereafter		-
Total minimum lease payments	$	3,337,710

10. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $2,565,836,896 and $2,214,734,297 for the years ended December 31, 2021 and 2020, respectively. The loss of the Contracts (which are generally renewed annually) or significant changes in the Medicare Advantage and Prescription Drug Plan programs as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2022, and all product offerings filed with CMS for 2022 have been approved.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the BBA and BIPA, generally, pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, the Company conducts medical record reviews as part of its data and payment accuracy compliance efforts, to more accurately reflect

diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below as well as ordinary course reviews of the Company's internal business processes.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2021, 75% of the risk score was calculated from claims data submitted through EDS. CMS will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for the payment years 2015 and 2014. CMS completed its RADV contract level audit of the 2012 payment year, but has not yet provided the results.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2016. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business

which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus or cash flows.

The Company will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

b. **COVID-19:** The emergence and spread of the novel coronavirus, or COVID-19, beginning in the first quarter of 2020, has impacted the Company's business. During periods of increased incidences of COVID-19, there was a reduction in non-COVID-19 hospital admissions and lower overall healthcare system consumption that decreased utilization. Likewise COVID-19 treatment and testing costs increased utilization. The significant disruption in utilization during 2020 also impacted the Company's ability to implement clinical initiatives to manage health care costs and chronic conditions of its members, and appropriately document their risk profiles, and, as such, significantly affected 2021 revenue under the risk adjustment payment model for MA plans. Finally, changes in utilization patterns and actions taken in 2020 and 2021 as a result of the

COVID-19 pandemic, including the suspension of certain financial recovery programs for a period of time and shifting the timing of claim payments and provider capitation surplus payments, impacted claim reserve development and operating cash flows for 2020 and 2021.

c. Legal Proceedings: During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus and cash flows, and may also affect the Company's reputation.

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

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

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. Securities & Credit Markets Risks: Ongoing volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or credit related impairments may be recorded in future periods.

Supplemental Investment Information

Humana Health Benefit Plan of Louisiana, Inc.
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2021

Of the **Humana Health Benefit Plan of Louisiana, Inc.**
Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436

NAIC Group Code 0119 NAIC Company Code 95642 Employer's ID Number 72-1279235
The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 4 of the statement of admitted assets, liabilities and surplus. $733,428,850.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	State Of Louisiana	Municipal	$ 126,801,826	17.29%
2.02	Federal Home Loan Banks	Bonds	51,942,213	7.08%
2.03	Federal Farm Credit Banks Funding Corporation	Bonds	37,904,317	5.17%
2.04	Federal National Mortgage Association	CMO, MBS	23,647,785	3.22%
2.05	Hyundai Capital America Inc.	Commercial Paper	14,999,083	2.05%
2.06	City of New Orleans	Municipal	14,037,761	1.91%
2.07	Bossier Parish Schools	Municipal	12,580,158	1.72%
2.08	East Baton Rouge Louisiana Sewerage Commission	Municipal	10,133,770	1.38%
2.09	Entergy Louisiana LLC	Bonds	8,682,560	1.18%
2.10	Shreveport Louisiana	Municipal	8,267,357	1.13%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 433,380,127	59.09%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	50,645,275	6.91%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	1,999,828	0.27%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	-	0.00%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	-	0.00%	3.12	P/RP-6	-	0.00%

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [X]	No [ ]
4.02	Total admitted assets held in foreign investments.	$	5,017,548	0.68%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	-	0.00%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
6.01	Country:	$	-	0.00%
6.02	Country:		-	0.00%
	Countries rated NAIC - 2			
6.03	Country:	$	-	0.00%
6.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
6.05	Country:	$	-	0.00%
6.06	Country:		-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1 Issuer	2 NAIC Rating	3	4
10.01			$ -	0.00%
10.02			-	0.00%
10.03			-	0.00%
10.04			-	0.00%
10.05			-	0.00%
10.06			-	0.00%
10.07			-	0.00%
10.08			-	0.00%
10.09			-	0.00%
10.10			-	0.00%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.			
11.02	Total admitted assets held in Canadian Investments	$	-	0.00%
11.03	Canadian-currency-denominated investments		-	0.00%
11.04	Canadian-denominated insurance liabilities		-	0.00%
11.05	Unhedged Canadian currency exposure		-	0.00%

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ -	0.00%
	Largest 3 investments with contractual sales restrictions		
12.03		-	0.00%
12.04		-	0.00%
12.05		-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1	2	3
	Name of Issuer		
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	JPMorgan Trust II - JPMorgan U.S. Treasury Plus Money Market Fund	$ 79,982,513	$ 79,982,513	$ -
14.07		-	-	-
14.08		-	-	-
14.09		-	-	-
14.10		-	-	-
14.11		-	-	-
14.12		-	-	-
14.13		-	-	-
14.14		-	-	-
14.15		-	-	-

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1	2	3
	Type (Residential, Commercial, Agricultural)		
16.02		$ -	0.00%
16.03		-	0.00%
16.04		-	0.00%
16.05		-	0.00%
16.06		-	0.00%
16.07		-	0.00%
16.08		-	0.00%
16.09		-	0.00%
16.10		-	0.00%
16.11		-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description		
	1	2	3
18.02		$ -	0.00%
18.03		-	0.00%
18.04		-	0.00%
18.05		-	0.00%
18.06		-	0.00%

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:	**2**	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	0	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Health Benefit Plan of Louisiana, Inc.
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2021

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1 Amount	2 Percentage	1 Amount	2 Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 3,468,343	0.62%	$ 3,468,343	0.62%
1.02	All other governments	-	0.00%	-	0.00%
1.03	U.S. states, territories and possessions, etc. guaranteed	98,387,515	17.55%	98,387,515	17.55%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	54,178,101	9.66%	54,178,101	9.66%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	190,686,607	34.02%	190,686,607	34.02%
1.06	Industrial and miscellaneous	124,305,580	22.18%	124,305,580	22.18%
1.07	Hybrid securities	-	0.00%	-	0.00%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	471,026,146	84.03%	471,026,146	84.03%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	-	0.00%	-	0.00%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	-	0.00%	-	0.00%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	-	0.00%	-	0.00%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	-	0.00%	-	0.00%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total valuation allowance	-	0.00%	-	0.00%
4.06	Total mortgage loans	-	0.00%	-	0.00%
5. Real estate					
5.01	Properties occupied by company	-	0.00%	-	0.00%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	-	0.00%	-	0.00%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	(5,431,684)	(0.97)%	(5,431,684)	(0.97)%
6.02	Cash equivalents	94,981,596	16.94%	94,981,596	16.94%
6.03	Short-term investments	-	0.00%	-	0.00%
6.04	Total cash, cash equivalents and short-term investments	89,549,912	15.97%	89,549,912	15.97%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		-	0.00%	-	0.00%
10. Receivables for securities		13,541	0.00%	13,541	0.00%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 560,589,599	100.00%	$ 560,589,599	100.00%

Humana Insurance Company

(a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2021 and 2020

Humana Insurance Company
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Statutory Basis of Accounting
December 31, 2021 and 2020

Report of Independent Auditors

To the Board of Directors of Humana Insurance Company

Opinions

We have audited the accompanying statutory financial statements of Humana Insurance Company (the "Company"), which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2021 and 2020, and the related statutory statements of revenue and expenses, of changes in surplus, and of cash flows for the years then ended, including the related notes (collectively referred to as the "financial statements").

Unmodified Opinion on Statutory Basis of Accounting

In our opinion, the accompanying financial statements present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the State of Wisconsin Office of the Commissioner of Insurance described in Note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the accompanying financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2021 and 2020, or the results of its operations or its cash flows for the years then ended.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the State of Wisconsin Office of the Commissioner of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the State of Wisconsin Office of the Commissioner of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the financial statements taken as a whole. The supplemental summary investment schedule and schedule of investment risk interrogatories (collectively referred to as the "supplemental schedules") of the Company as of December 31, 2021 and for the year then ended are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 29, 2022

Humana Insurance Company
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2021 and 2020

	2021	2020
Admitted Assets		
Cash and invested assets		
Bonds	$ 4,220,270,657	$ 4,107,067,395
Investment in subsidiaries	754,872,629	742,129,787
Mortgage notes receivable from Humana Inc.	8,550,000	8,550,000
Real estate occupied by the Company	21,120	10,899,516
Receivable for securities	810,000	35,000
Short-term investments	69,999	167,389,639
Other invested assets	49,969,673	-
Total invested assets	5,034,564,078	5,036,071,337
Cash	18,820,156	126,828,448
Cash equivalents	84,740	1,180,710,045
Total cash and invested assets	5,053,468,974	6,343,609,830
Premiums receivable	735,524,660	548,604,973
Investment income due and accrued	23,808,330	24,038,784
Amounts receivable relating to uninsured plans	1,480,315,753	1,129,286,621
Reinsurance receivable	9,884,168	5,765,945
Health care and other receivables	1,126,405,541	923,081,452
Current federal income tax recoverable	57,458,049	66,243,478
Net deferred tax assets	133,101,137	130,573,948
Electronic data processing equipment and software, less accumulated depreciation of $77,121,435 and $57,073,508 in 2021 and 2020, respectively	31,417,823	38,615,372
Receivable from Humana Inc.	265,908,400	183,694,631
Total admitted assets	$ 8,917,292,835	$ 9,393,515,034
Liabilities		
Benefits and loss adjustment expenses payable	$ 3,139,407,842	$ 3,291,927,287
Aggregate health policy reserves	542,394,142	644,149,128
Aggregate health claim reserves	194,163	821,860
Advance premiums	109,243,047	154,085,273
Accounts payable and accrued expenses	1,004,100,307	918,816,129
Funds held under reinsurance treaties	7,993,395	8,351,534
Total liabilities	4,803,332,896	5,018,151,211
Surplus		
Common stock, $8.00 par value; 15,000,000 shares authorized; 1,104,167 shares issued and outstanding	8,833,336	8,833,336
Paid-in surplus	2,105,092,362	2,105,092,362
Unassigned surplus	2,000,034,241	2,261,438,125
Total surplus	4,113,959,939	4,375,363,823
Total liabilities and surplus	$ 8,917,292,835	$ 9,393,515,034

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2021 and 2020

	2021	2020
Earned premiums and other revenues, net of reinsurance	$ 28,813,021,888	$ 28,877,184,688
Expenses		
Benefits incurred and loss adjustment expenses	25,617,804,107	24,380,288,125
Selling, general and administrative expenses	2,754,216,060	3,184,891,087
Changes in aggregate health policy reserves	61,850,345	80,887,629
Total expenses	28,433,870,512	27,646,066,841
Net underwriting gain	379,151,376	1,231,117,847
Net investment income	207,993,680	292,447,541
Net realized capital gains on investments (net of capital gains tax of $15,215,177 and $19,620,490, respectively)	38,410,398	738,848
Net other income	2,188,544	1,299,783
Income before federal income tax expense	627,743,998	1,525,604,019
Federal income tax expense	96,472,851	398,875,632
Net income	$ 531,271,147	$ 1,126,728,387

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2021 and 2020

	Common Stock		Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
	Shares	Amount				
Balances at January 1, 2020	1,104,167	$ 8,833,336	$ 510,143,497	$ 2,105,092,362	$ $ 1,505,335,800	$ 4,129,404,995
Net income	-	-	-	-	1,126,728,387	1,126,728,387
HCRL fee moratorium	-	-	(510,143,497)	-	510,143,497	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	66,297,981	66,297,981
Change in net deferred income taxes	-	-	-	-	42,171,191	42,171,191
Change in nonadmitted assets	-	-	-	-	(39,238,731)	(39,238,731)
Dividends or return of capital paid	-	-	-	-	(950,000,000)	(950,000,000)
Balances at December 31, 2020	1,104,167	8,833,336	-	2,105,092,362	2,261,438,125	4,375,363,823
Net income	-	-	-	-	531,271,147	531,271,147
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(668,032)	(668,032)
Change in net deferred income taxes	-	-	-	-	11,190,960	11,190,960
Change in nonadmitted assets	-	-	-	-	(53,197,959)	(53,197,959)
Dividends or return of capital paid	-	-	-	-	(750,000,000)	(750,000,000)
Balances at December 31, 2021	1,104,167	$ 8,833,336	$ -	$ 2,105,092,362	$ $ 2,000,034,241	$ 4,113,959,939

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2021 and 2020

	2021	2020
Cash flows from operations		
Premiums collected, net of reinsurance	$ 28,420,572,881	$ 28,971,886,654
Net investment income received	116,737,925	142,213,600
Net other income received	(2,185,060)	-
Benefits paid	(25,022,673,540)	(22,495,260,427)
Selling, general and administrative expenses paid	(4,023,878,198)	(4,845,676,344)
Federal income taxes paid	(102,902,599)	(495,411,398)
Net cash (used for) from operations	(614,328,591)	1,277,752,085
Cash flows from investments		
Proceeds from investments sold or matured	2,214,486,299	1,735,579,294
Cost of investments acquired	(2,199,086,594)	(2,079,870,427)
Net cash from (used for) investments	15,399,705	(344,291,133)
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(750,000,000)	(950,000,000)
Other cash applied	(107,024,351)	(79,627,354)
Net cash used for financing and miscellaneous sources	(857,024,351)	(1,029,627,354)
Net change in cash, cash equivalents and short-term investments	(1,455,953,237)	(96,166,400)
Cash, cash equivalents and short-term investments		
Beginning of year	1,474,928,132	1,571,094,534
End of year	$ 18,974,895	$ 1,474,928,132

The accompanying notes are an integral part of these statutory basis financial statements.

1. Reporting Entity

Humana Insurance Company (the Company), a wholly owned subsidiary of CareNetwork Inc., a wholly owned subsidiary of Humana Inc. (Humana), is a life, accident, and health insurance company domiciled in the state of Wisconsin and is authorized to sell life, accident and health products therein and in 53 states and territories including the District of Columbia, Guam, American Samoa, the Northern Mariana Islands and the U.S. Virgin Islands. The Company is subject to regulation by the federal government, the Wisconsin Office of the Commissioner of Insurance (the OCI) and the insurance departments of the states in which it is licensed. State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 8, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 7.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 12(a).

As part of the Company's individual Medicare Advantage products, it also offers Dual Eligible Special Needs (D-SNP) plans. In connection with offering a D-SNP plan in a particular state, the Company is required to enter into a special coordinating contract with the applicable state Medicaid agency.

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the OCI, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(t), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Policy and contract liabilities are reported net of reinsurance ceded amounts and any gains from reinsurance transactions are included as a component of surplus, whereas under GAAP, assets and liabilities related to reinsurance ceded contracts are reported on a gross basis and reinsurance transaction gains are reported as a liability;

viii. Investments in subsidiaries are carried at their underlying statutory equity value with changes in value being recorded directly to surplus, whereas under GAAP, these subsidiaries would be consolidated;

ix. Administrative service fees received from customers on an uninsured basis are deducted from general administrative expenses, whereas under GAAP, these administrative fees are reported as revenue within the income statement;

x. Comprehensive income disclosures required by GAAP are omitted; and

xi. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

xii. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The OCI adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The OCI has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. No deviations from the Codification currently exist.

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health

Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage (MA) premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases the Company's effective tax rate, was in effect for calendar year 2020 and permanently repealed beginning in calendar year 2021. The annual health insurance industry fee levied on the insurance industry was $15.5 billion in 2020.

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

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, create uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. Cash, Cash Equivalents and Short-Term Investments: The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Short-term investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. Investments: Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds, cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2021 or December 31, 2020.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2021 or 2020.

For other restricted assets reported in aggregate, the pledged amounts with the OCI and other state departments of insurance were $11,289,272 and $11,301,477, which is 0.12% and 0.12% of gross assets and 0.13% and 0.12% of net admitted assets, at December 31, 2021 and 2020, respectively. These investments, generally U.S. Treasury obligations and money market mutual funds, were on deposit at December 31, 2021 and 2020 to satisfy requirements of regulatory agencies. These assets are included in bonds and cash equivalents in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

e. Fair Value: In accordance with SSAP No. 100R, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

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

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. Fair value of privately held investment grade debt securities are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held investment grade debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business with similar credit characteristics, and reviewing the underlying financial performance including estimating discounted cash flows. The Company obtains at least one price for each

security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2021 or 2020.

The fair value of financial assets carried at fair value at December 31, 2021 and 2020 were as follows:

	Fair Value Measurements at December 31, 2021			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	$ -	$ 157,809	$ -	$ 157,809
Corporate debt securities	-	78,738,491	-	78,738,491
Total invested assets	$ -	$ 78,896,300	$ -	$ 78,896,300

	Fair Value Measurements at December 31, 2020			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	$ -	$ 222,629	$ -	$ 222,629
Corporate debt securities	-	12,620,988	-	12,620,988
Total invested assets	$ -	$ 12,843,617	$ -	$ 12,843,617

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2021 and 2020 were as follows:

	December 31, 2021					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 4,255,216,440	$ 4,220,425,396	$ 77,704	$ 4,222,515,065	$ 32,623,671	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 4,263,766,440	$ 4,228,975,396	$ 77,704	$ 4,222,515,065	$ 41,173,671	$ -

	December 31, 2020					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 5,652,736,110	$ 5,455,167,079	$ 1,092,956,754	$ 4,559,779,356	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 5,661,286,110	$ 5,463,717,079	$ 1,092,956,754	$ 4,559,779,356	$ 8,550,000	$ -

f. Real Estate and Long-Lived Assets: Real estate occupied by the Company is carried at the depreciated cost. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from ten to twenty years. Depreciation expense on real estate occupied by the Company was $1,036,116 and $1,760,633 for the years ended December 31, 2021 and 2020, respectively.

The Company periodically reviews long-lived assets, including property and equipment, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in the Company's operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. The Company recognizes an impairment loss based on the excess of the carrying value over the fair value of the asset. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, the Company periodically reviews the estimated lives of all long-lived assets for reasonableness.

g. Federal Home Loan Bank (FHLB) Agreements

The Company is a member of the Federal Home Loan Bank (FHLB) of Cincinnati. At December 31, 2021, the Company had no outstanding borrowings with the FHLB. The Company has determined the actual maximum borrowing capacity to be $0. The Company calculated this is accordance with current FHLB capital stock.

The amount of FHLB capital stock held by the Company at December 31, 2021 and 2020 was:

	2021	2020
Membership Stock - Class A	$ -	$ -
Membership Stock - Class B	9,393,515	-
Activity Stock	-	-
Excess Stock	3,035,585	-
Aggregate Total	$ 12,429,100	$ -
Actual or estimated borrowing capacity	$ -	$ -

The Company's current year Class B membership stock of $12,429,100 was not eligible for redemption. The Company did not have any collateral pledged to or borrowings from the FHLB as of December 31, 2021 or any collateral pledged to or borrowings from the FHLB at any time during the current year.

h. Investment in subsidiaries: In accordance with SSAP No. 97, *Investments in Subsidiary, Controlled, and Affiliated Entities,* a replacement of SSAP No. 88 (SSAP No. 97), $754,872,629 and $742,129,787 were admitted as investment in subsidiaries at December 31, 2021 and 2020, respectively. The Company owns 100% of the common stock of Humana Employers Health Plan of Georgia, Inc. (HEHPGA), Humana Insurance Company of Kentucky (HICK), and Humana Health Benefit Plan of Louisiana, Inc. (HHBPLA). The Company accounts for its investment in subsidiaries using the statutory equity method of accounting.

The Company reports an investment in an insurance subsidiary, HHBPLA, for which the audited statutory equity reflects a departure from the NAIC statutory accounting practices and procedures. The Commissioner of Insurance of the State of Louisiana allowed HHBPLA to admit its $595,636 and $719,533 of furniture and equipment used for Health Maintenance Organization operations in 2021 and 2020, respectively, which is not in accordance with NAIC SSAP. Had HHBPLA not been allowed to admit these balances, their ending surplus at December 31, 2021 and 2020 would have been $370,320,902 and $344,369,369, respectively. The Company's risk-based capital would have not triggered a regulatory event had it not used a prescribed or permitted practice.

i. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other income in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from 3 to 10 years. Depreciation expense, including that related to the nonadmitted portion, was $25,005,269 and $26,158,063 for the years ended December 31, 2021 and 2020, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements, including that related to the nonadmitted portion, was $3,247,700 and $2,129,330 for the years ended December 31, 2021 and 2020, respectively.

j. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending

on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2021 and 2020 DTAs of $26,792,852 and $18,129,081, respectively, were nonadmitted.

k. Earned Premiums: Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for its membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage

to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022.

The amount of net premiums written by the Company in 2021 and 2020 that were subject to retrospective rating features were $27,185,195,833 and $27,296,362,970, respectively, or 94.34% and 94.53%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $422,528,730 and $318,241,471 as of December 31, 2021 and 2020, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company recorded the following amounts at December 31, 2021 and 2020 for policyholder rebates:

	2021					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred (recovered)	$ (83,860)	$ 749,696	$ (6,921)	$ 658,915	$ 7,589,904	$ 8,248,819
Medical loss ratio rebates paid	4,257,262	634,983	336,219	5,228,464	68,311,632	73,540,096
Medical loss ratio rebates unpaid	-	564,579	34,886	599,465	48,557,090	49,156,555

	2020					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred	$ 4,341,122	$ 3,129,358	$ (1,623,507)	$ 5,846,973	$ 55,177,890	$ 61,024,863
Medical loss ratio rebates paid	-	2,837,212	346,527	3,183,739	14,581,350	17,765,089
Medical loss ratio rebates unpaid	4,341,122	449,866	378,026	5,169,014	109,278,818	114,447,832

The amounts recorded for the medical loss rebates incurred are recorded as a reduction of premium in earned premiums in the accompanying statutory statements of revenue and expenses. The medical loss rebates unpaid are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

There is no impact of any reinsurance assumed or ceded on the medical loss ratio rebate.

I. Medicare Part D: The Company covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments received monthly from CMS and members, which are determined from the Company's annual bid, represent amounts for providing prescription drug insurance coverage. The Company recognizes premiums revenue for providing

this insurance coverage ratably over the term of its annual contract. The CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which the Company is not at risk.

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. The 2020 settlement with CMS did not occur in the current year.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2021 and 2020:

	2021		2020	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 241,378,094	$ -	$ 128,324,320	$ -
Amounts receivable relating to uninsured plans	-	1,451,968,801	-	1,119,108,271
Aggregate health policy reserves	(110,575,363)	-	(85,986,712)	-
Accounts payable and accrued expenses	-	(195,781,447)	-	(162,274,651)
Net asset	$ 130,802,731	$ 1,256,187,354	$ 42,337,608	$ 956,833,620

m. Accounting for the Risk-Sharing Provisions of the Health Care Reform Law: Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members

and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company risk adjustment data for 2018 and 2019 was selected for audit by HHS. The final assessment from this audit was immaterial to the statutory statements of revenues and expenses.

The temporary risk corridor program applied to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including the Company's small group health plans, were not subject to the risk corridor program. The risk corridor provisions were included to limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to the Company or require it to refund HHS a portion of the premiums the Company received.

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2021 and 2020:

HCRL Risk Adjustment		
Assets	**2021**	**2020**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 9,936,620	$ 8,452,650
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	259,993	226,810
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	5,387,029	8,877,129
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	13,233,365	12,371,151
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	103,878	99,711

HCRL Risk Corridor	2021	2020
Assets		
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	-	51,059,517
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 18,112,622	$ -	$ 18,112,622	$ -	$ -	$ -
2015	17,262,854	-	17,262,854	-	-	-
2016	18,717,446	-	18,717,446	-	-	-
Total	$ 54,092,922	$ -	$ 54,092,922	$ -	$ -	$ -

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal government for payments under the risk corridor premium stabilization program established under the HCRL for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, the Company received $51,059,517 from the U.S Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $51,059,517 payment received from the U.S Government and $2,552,205 in related fees and expenses are reflected in net premium income and selling, general and administrative expenses, respectively.

The transitional reinsurance program required the Company to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the HCRL in the individual commercial market were eligible for recoveries if individual claims exceed a specified threshold. Accordingly, the Company accounted for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in its statutory statements of revenue and expenses. The Company accounted for contributions made by individual commercial plans compliant with the HCRL, which were subject to recoveries, as ceded premiums (a reduction of earned premiums) and similarly the Company accounted for any recoveries as ceded benefits (a reduction of benefits incurred and loss adjustment expenses) in its statutory statements of revenue and expenses.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses does not include any amounts associated with the transitional HCRL reinsurance program as of December 31, 2021 and 2020.

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	8,452,650		14,695,001		(6,242,351)		6,490,983		A.	248,632	
2. Premium adjustments (payables) (including high risk pool payments)		(8,877,129)		(6,435,707)		(2,441,422)		(730,948)	B.		(3,172,370)
3. Subtotal ACA Permanent Risk Adjustment Program	8,452,650	(8,877,129)	14,695,001	(6,435,707)	(6,242,351)	(2,441,422)	6,490,983	(730,948)		248,632	(3,172,370)
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		-		-		-			-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance-not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-

c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		-		-		-			-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	-	-	-	-	-	-		-	-
d. Total for ACA Risk Sharing Provisions	8,452,650	(8,877,129)	14,695,001	(6,435,707)	(6,242,351)	(2,441,422)	6,490,983	(730,948)		248,632	(3,172,370)

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2020 benefit year and the latest data from Wakely Consulting.

B. Adjustments related to updates received from CMS associated with 2020 benefit year and the latest data from Wakely Consulting.

Net collections under the 3Rs associated with prior coverage years were $8,259,294 and $62,307,691 in 2021 and 2020, respectively.

n. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 9. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2021, 2020, and 2019:

Quarter	Estimate Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days after Billing
12/31/2021	$ 1,121,259,678	$ 1,121,259,678	$ -	$ -	$ -
9/30/2021	1,124,367,299	1,118,965,164	1,100,651,492	-	-
6/30/2021	1,321,598,222	1,334,320,192	1,326,313,366	-	-
3/31/2021	1,170,178,920	1,187,840,966	1,185,861,272	-	1,697,017
12/31/2020	865,801,825	865,801,825	864,909,890	-	630,125
9/30/2020	1,168,556,064	1,168,556,064	1,160,387,128	7,456,939	711,997
6/30/2020	1,373,937,740	1,373,937,740	1,362,660,688	10,170,454	1,106,598
3/31/2020	1,082,989,376	1,082,989,376	1,058,456,911	24,387,760	137,566
12/31/2019	857,149,998	857,149,998	852,653,167	-	4,496,831
9/30/2019	983,974,614	983,974,614	976,954,193	2,515,299	4,505,122
6/30/2019	1,557,140,947	1,557,140,947	1,538,340,203	4,788,022	14,012,722
3/31/2019	1,105,668,614	1,105,668,614	1,095,342,361	-	10,326,253

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $26,872,124 and $16,517,875 were nonadmitted at December 31, 2021 and 2020, respectively.

o. Risk-Share Agreements: The Company negotiates contractual agreements with group Medicare customers, some of which contain gain sharing provisions in the event the benefit ratio is less than an agreed-upon level. In these agreements, the Company and the customers generally share evenly in the gain. The Company recorded gain share payable of $52,498,336 and $175,887,987 as of December 31, 2021 and 2020, respectively, which is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

p. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued.

The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $136,749,001 and $77,622,000 at December 31, 2021 and 2020, respectively, which are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

q. Reserves for Life Contracts and Deposit-Type Contracts: The Company waives the deduction of deferred fractional premiums upon death of the insured and holds net level or modified premium reserves on mortality and interest bases that are consistent with statutory guidance. The Company does not return any portion of the final premium for periods beyond the date of death. Surrender values are not promised in excess of the legally computed reserves.

As of December 31, 2021 and 2020 the Company did not have any life insurance in force for which the gross premiums were less than the net premiums according to the standard valuation set by the OCI, as described in SSAP No. 51, *Life Contracts* (SSAP No. 51). As discussed in Note 8, all non-health insurance business, including all associated reserves, was ceded to Humana Insurance Company of Kentucky (HICK) as of January 1, 2013.

r. Administrative Service Only Contracts (ASO): Administrative services fees cover the processing of claims, offering access to the Company's provider networks and clinical programs and responding to customer service inquiries from members of self-funded groups. Fees from providing administrative services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by

the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from Humana to cover catastrophic claims or to limit aggregate annual costs. The Company does not reflect payment of ASO claims in its statutory statements of revenue and expenses.

s. Mortgage Loans: Mortgage loans are current and carried at unpaid principal balances, net of discounts/premiums and valuation allowances. The Company has estimated the book/adjusted carrying value of its mortgage loans to be $8,550,000 at December 31, 2021 and 2020. This estimate was established using a discounted cash flow method based on rating, maturity and future income when compared to the expected yield for mortgages having similar characteristics. The rating for mortgages in good standing is based on property type, location, market conditions, occupancy, debt service coverage, loan to value, caliber of tenancy, borrower and payment record. Problem mortgages are priced to reflect their monetary value to the Company, considering such things as the degree of default, whether or not the payments are still being made, interest rate, maturity and operating performance of the underlying collateral.

During 2021 and 2020, the maximum and minimum lending rates for mortgage loans were 6.65% at both year ends. At the issuance of a loan, the percentage of loan to value on any one loan does not exceed 100.

t. Nonadmitted Assets: Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

u. Going Concern Considerations: Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

v. Subsequent Events: The Company evaluated subsequent events through April 29, 2022, the date these financial statements were issued or available to be issued.

The Company is not aware of any events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements, which may have a material effect on its financial condition.

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2021 and 2020 were as follows:

	2021			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 14,504,506	$ 83	$ (264,502)	$ 14,240,087
All other governments	23,473,727	59,081	(541,040)	22,991,768
States, territories and possessions	10,056,786	300,132	-	10,356,918
Political subdivisions of states, territories and possessions	43,516,707	937,471	(381,441)	44,072,737
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,235,895,362	21,116,925	(20,848,402)	1,236,163,885
Industrial and miscellaneous	2,878,348,569	57,091,552	(22,881,465)	2,912,558,656
Hybrid Securities	14,475,000	202,650	-	14,677,650
Total bonds	$ 4,220,270,657	$ 79,707,894	$ (44,916,850)	$ 4,255,061,701

	2020			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 86,450,865	$ 747,748	$ (91,962)	$ 87,106,651
All other governments	-	-	-	-
States, territories and possessions	40,724,739	1,351,861	(129)	42,076,471
Political subdivisions of states, territories and possessions	60,193,948	2,047,422	-	62,241,370
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,426,364,809	65,255,683	(658,855)	1,490,961,637
Industrial and miscellaneous	2,493,333,034	130,020,825	(1,099,566)	2,622,254,293
Hybrid securities	-	-	-	-
Total bonds	$ 4,107,067,395	$ 199,423,539	$ (1,850,512)	$ 4,304,640,422

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2021, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 69,541,749	$ 70,170,375
Due after one year through five years	695,989,780	715,425,794
Due after five years through ten years	1,139,608,321	1,152,575,558
Due after ten years	489,411,413	495,158,964
Mortgage and asset-backed securities	1,825,789,394	1,821,801,010
	$ 4,220,340,657	$ 4,255,131,701

The detail of realized gains (losses) of bonds for the years ended December 31, 2021 and 2020 were as follows:

	2021	2020
Gross realized gains	$ 45,925,545	$ 24,861,753
Gross realized losses	(3,562,011)	(4,502,415)
Net realized gains	$ 42,363,534	$ 20,359,338

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2021 and 2020 were as follows:

	2021					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 7,960,839	$ (84,441)	$ 5,347,709	$ (180,061)	$ 13,308,548	$ (264,502)
All other governments	9,117,488	(541,040)	-	-	9,117,488	(541,040)
States, territories and possessions	-	-	-	-	-	-
Political subdivisions of states, territories and possessions	16,661,714	(381,441)	-	-	16,661,714	(381,441)
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	848,054,594	(20,844,704)	103,082	(3,698)	848,157,676	(20,848,402)
Industrial and misc.	1,178,067,017	(21,790,277)	21,805,947	(1,091,188)	1,199,872,964	(22,881,465)
Hybrid securities	-	-	-	-	-	-
Total invested assets	$ 2,059,861,652	$ (43,641,903)	$ 27,256,738	$ (1,274,947)	$ 2,087,118,390	$ (44,916,850)

	2020					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 47,281,417	$ (91,962)	$ -	$ -	$ 47,281,417	$ (91,962)
All other governments	-	-	-	-	-	-
States, territories and possessions	7,304,848	(129)	-	-	7,304,848	(129)
Political subdivisions of states, territories and possessions	-	-	-	-	-	-
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	80,636,584	(658,855)	-	-	80,636,584	(658,855)
Hybrid securities	-	-	-	-	-	-
Industrial and misc.	222,903,328	(611,678)	114,016,835	(487,888)	336,920,163	(1,099,565)
Total invested assets	$ 358,126,177	$ (1,362,624)	$ 114,016,835	$ (487,888)	$ 472,143,012	$ (1,850,512)

The unrealized loss from all debt securities was generated from 323 investment positions at December 31, 2021. All issuers of debt securities the Company owns that were trading at an unrealized loss at December 31, 2021 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2021, the Company did not intend to sell any debt securities with an unrealized loss position, and it is not likely that the Company will be required to sell these debt securities before recovery of their amortized cost basis. As a result, the Company believes that the debt securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2021.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Reinsurance

The Company reinsures portions of its business through various reinsurance treaties. These treaties protect the Company from sustaining losses above predetermined levels and are included as a reduction of earned premiums in the accompanying statements of revenue and expenses. Although the reinsurer in each case is primarily liable on the insurance ceded, the Company remains liable to the insured whether or not the reinsurer meets its contractual obligations.

In 2021 and 2020, the Company did not commute any ceded reinsurance, nor did it enter into or engage in any agreement that reinsures policies or contracts that were in-force or had existing reserves as of the effective date of such agreements. No write-offs of reinsurance balances occurred in 2021 or 2020. The Company remains obligated for amounts ceded in the event that reinsurers do not meet their obligations.

The Company has a reinsurance contract with an affiliate as noted within Note 9. For the years ended December 31, 2021 and 2020 there were $48,194,987 and $48,245,098 premiums ceded, respectively, related to this contract.

The Company has not entered into any reinsurance agreements in which the reinsurer may unilaterally cancel any reinsurance for reasons other than nonpayment of premiums or other amounts due. The Company does not have any reinsurance agreements in effect in which the amount of losses paid or accrued through December 31, 2021 or 2020 would result in a payment to the reinsurer of amounts which, in the aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premiums collected under the reinsured policies. The Company does not have any reinsurance agreements subject to A-791 risk limiting provisions.

5. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2021 and 2020 were as follows:

	2021		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 161,542,755	$ 814,552	$ 162,357,307
Statutory valuation allowance adjustment	-	(814,552)	(814,552)
Adjusted gross deferred tax assets	161,542,755	-	161,542,755
Deferred tax assets nonadmitted	(26,792,852)	-	(26,792,852)
Subtotal net admitted deferred tax assets	134,749,903	-	134,749,903
Gross deferred tax liabilities	(1,648,766)	-	(1,648,766)
Net admitted deferred tax asset/(liability)	$ 133,101,137	$ -	$ 133,101,137

	2020		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 154,254,430	$ 31,678	$ 154,286,108
Statutory valuation allowance adjustment	-	(31,678)	(31,678)
Adjusted gross deferred tax assets	154,254,430	-	154,254,430
Deferred tax assets nonadmitted	(18,129,081)	-	(18,129,081)
Subtotal net admitted deferred tax assets	136,125,349	-	136,125,349
Gross deferred tax liabilities	(5,551,401)	-	(5,551,401)
Net admitted deferred tax asset/(liability)	$ 130,573,948	$ -	$ 130,573,948

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2021 and 2020 were as follows:

	December 31, 2021		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 127,782,401	$ -	$ 127,782,401
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	5,318,736	-	5,318,736
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	5,318,736
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	592,416,147
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	1,648,766	-	1,648,766
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 134,749,903	$ -	$ 134,749,903

	December 31, 2020		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 126,823,217	$ -	$ 126,823,217
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	3,750,731	-	3,750,731
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	3,750,731
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	630,926,175
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	5,551,401	-	5,551,401
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 136,125,349	$ -	$ 136,125,349

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2021	2020
Ratio percentage used to determine recovery period and threshold limitation amount	349%	390%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 3,949,440,979	$ 4,206,174,503

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2021 and 2020 consisted of the following:

	2021	2020
Current year income tax provision	$ 97,716,253	$ 404,289,613
Revisions in prior years' estimated taxes	(1,243,402)	(5,413,981)
Federal income tax expense excluding the tax on realized capital gains and before change in net deferred income taxes	96,472,851	398,875,632
Tax on realized capital gains	15,215,177	19,620,490
Change in net deferred income taxes	(11,190,960)	(42,171,191)
Total statutory income taxes	$ 100,497,068	$ 376,324,931

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2021 and 2020 were as follows:

	2021	2020	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 55,843,491	$ 51,347,974	$ 4,495,517
Advance premiums	4,530,615	6,407,783	(1,877,168)
Policyholder reserves	285,568	234,972	50,596
Investments	-	-	-
Deferred acquisition costs	36,093,002	30,714,469	5,378,533
Policyholder dividends accrual	-	-	-
Fixed assets	534,399	-	534,399
Compensation and benefit accruals	25,357,721	22,884,214	2,473,507
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	3,019,461	3,060,058	(40,597)
Bad debts	2,334,403	-	2,334,403
Accrued litigation	159,348	1,646,820	(1,487,472)
CMS Rx reserves	25,521,929	23,812,375	1,709,554
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	2,327,321	1,459,228	868,093
Accrued lease	2,371,892	2,120,779	251,113
Section 197 intangibles	232,172	266,567	(34,395)
Premium rebates MER	463,741	8,603,109	(8,139,368)
Provider contracts	2,467,692	1,696,082	771,610
Premium acquisition expense	-	-	-
Gross ordinary DTAs	161,542,755	154,254,430	7,288,325
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(26,792,852)	(18,129,081)	(8,663,771)
Admitted ordinary DTAs	134,749,903	136,125,349	(1,375,446)
Capital			
Investments	814,552	31,678	782,874
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	814,552	31,678	782,874
Statutory valuation allowance adjustment	(814,552)	(31,678)	(782,874)
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 134,749,903	$ 136,125,349	$ (1,375,446)

	2021	2020	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	-	(3,160,279)	3,160,279
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(120,886)	(72,486)	(48,400)
Bad debts	-	(408,785)	408,785
Reserve transition adjustment	(1,527,880)	(1,909,851)	381,971
Accrued lease	-	-	-
Ordinary DTLs	(1,648,766)	(5,551,401)	3,902,635
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(1,648,766)	(5,551,401)	3,902,635
Net deferred tax assets/(liabilities)	$ 133,101,137	$ 130,573,948	$ 2,527,189

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the ordinary portion of the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no ordinary DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from. A statutory valuation allowance has been set up for deferred taxes on future capital loss items, due to uncertainty regarding the timing of their reversal.

The change in nonadmitted deferred tax assets from December 31, 2020 to 2021 was an increase of $8,663,771. The change in nonadmitted deferred tax assets from December 31, 2019 to 2020 was an increase of $4,861,189.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the dividends received deduction, change to nonadmitted assets and deferred tax true-ups and tax-exempt interest in 2021.

The Company had no net operating loss carryforwards at December 31, 2021 or 2020.

The following table demonstrates the income tax expense for 2020 and 2021 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2020	$ 403,046,212	$ 19,620,490	$ 422,666,702
2021	97,716,253	15,215,177	112,931,430
	$ 500,762,465	$ 34,835,667	$ 535,598,132

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2021 or 2020.

As of December 31, 2021, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2020 and prior years. Humana's 2021 tax return is under advance review by the IRS under the Compliance Assurance Process. Humana's 2021 tax return is under advance review by the IRS under CAP. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2021 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2021
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	ABERDEEN HOLDINGS, INC.	72-2695805
6	ABLE HOME HEALTHCARE, INC.	77-0601595
7	ADVANCED ONCOLOGY SERVICES, INC.	65-0180784
8	ALPINE HOME HEALTH CARE, LLC	36-4473376
9	AMERICAN HOMECARE MANAGEMENT CORP.	11-3306095
10	AMERICAN HOSPICE, INC.	75-2486047
11	AMICUS MEDICAL CENTER, LLC	45-4020797
12	AMICUS MEDICAL GROUP, INC.	27-3974953

13	AMICUS MEDICAL SERVICES ORGANIZATION, LLC	27-1085323
14	ARCADIAN HEALTH PLAN, INC.	20-1001348
15	ASIAN AMERICAN HOME CARE, INC.	94-3247811
16	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
17	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
18	CARENETWORK, INC.	39-1514846
19	CAREPLUS HEALTH PLANS, INC.	59-2598550
20	CARITEN HEALTH PLAN INC.	62-1579044
21	CENTERWELL CARE SOLUTIONS, INC. (f/k/a PRIMARY CARE MANAGEMENT, INC.)	85-0858631
22	CENTERWELL SENIOR PRIMARY CARE (FL), INC. (f/k/a FAMILY PHYSICIANS OF WINTER PARK, INC.)	59-3164234
23	CENTERWELL SENIOR PRIMARY CARE (KS), P.A. (f/k/a PARTNERS IN PRIMARY CARE (KS), P.A.)	30-1236218
24	CENTERWELL SENIOR PRIMARY CARE (MO), P.C. (f/k/a PARTNERS IN PRIMARY CARE (MO), P.C.)	85-3676937
25	CENTERWELL SENIOR PRIMARY CARE (NC), P.C. (f/k/a PARTNERS IN PRIMARY CARE (NC), P.C.)	82-1926920
26	CENTERWELL SENIOR PRIMARY CARE (SC), P.C. (f/k/a PARTNERS IN PRIMARY CARE (SC), P.C.)	85-3577914
27	CENTRAL ARIZONA HOME HEALTH CARE, INC.	86-0714789
28	CH SERVICES GROUP HOLDINGS, INC.	47-3061031
29	CH SERVICES HOLDINGS, INC.	47-3083265
30	CH SERVICES MIDCO HOLDINGS, INC.	47-3083393
31	CHA HMO, INC.	61-1279717
32	CHAPARRAL HOSPICE, INC.	35-2224605
33	CHARLOTTE BUYER, INC.	82-5266576
34	COMPASS HOSPICE, INC.	27-0001235
35	COMPBENEFITS COMPANY	59-2531815
36	COMPBENEFITS CORPORATION	04-3185995
37	COMPBENEFITS DENTAL, INC.	36-3686002
38	COMPBENEFITS DIRECT, INC.	58-2228851
39	COMPBENEFITS INSURANCE COMPANY	74-2552026
40	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
41	CONTINUCARE CORPORATION	59-2716023
42	CONVIVA HEALTH MANAGEMENT, LLC	46-5329373
43	CONVIVA HEALTH MSO OF TEXAS, INC.	46-1225873
44	CONVIVA MEDICAL CENTER MANAGEMENT OF TEXAS, P.A.	47-1161014
45	CURO HEALTH SERVICES HOLDINGS, INC.	27-3569032
46	CURO TEXAS HOLDINGS, LLC	46-3096415
47	CURO UTAH HOME CARE, INC.	27-3500910
48	CURO UTAH HOSPICE, INC.	27-3500790
49	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
50	DENTICARE, INC.	76-0039628
51	EAGLE RX HOLDCO, INC.	47-1407967
52	EAGLE RX, INC.	47-1416614
53	EDGE HEALTH MSO, INC.	84-2214810
54	EDGE HEALTH, P.C.	84-2752906
55	EMPHESYS INSURANCE COMPANY	31-0935772
56	EMPHESYS, INC.	61-1237697
57	ENCLARA PHARMACIA, INC.	23-3068914

58	FHI GP, INC.	75-2588220
59	FHI HEALTH SYSTEMS, INC.	75-2588219
60	FHI LP, INC.	88-0335145
61	FIRST HOME HEALTH, INC.	55-0750157
62	FOCUS CARE HEALTH RESOURCES, INC.	75-2784006
63	FPG ACQUISITION CORP.	81-3802918
64	FPG ACQUISITION HOLDINGS CORP.	81-3819187
65	FPG HOLDING COMPANY, LLC	32-0505460
66	GBA HOLDING, INC.	75-2855493
67	GENERATIONS HOSPICE SERVICE CORPORATION	42-1581419
68	GENTIVA CERTIFIED HEALTHCARE CORP.	11-2645333
69	GENTIVA HEALTH SERVICES (CERTIFIED), INC.	11-3454105
70	GENTIVA HEALTH SERVICES HOLDING CORP.	11-3454104
71	GENTIVA HEALTH SERVICES, INC.	36-4335801
72	GENTIVA SERVICES OF NEW YORK, INC.	11-2802024
73	GILBERT'S HOME HEALTH AGENCY, INC.	64-0730826
74	GIRLING HEALTH CARE SERVICES OF KNOXVILLE, INC.	62-1406895
75	GIRLING HEALTH CARE, INC.	74-2115034
76	GUIDANTRX, INC.	39-1789830
77	HARRIS, ROTHENBERG INTERNATIONAL INC.	27-1649291
78	HAWKEYE HEALTH SERVICES, INC.	42-1285486
79	HEALTH VALUE MANAGEMENT, INC.	61-1223418
80	HHS HEALTHCARE CORP.	90-0527683
81	HOME HEALTH CARE AFFILIATES OF MISSISSIPPI, INC.	62-1775256
82	HOME HEALTH CARE AFFILIATES, INC.	74-2737989
83	HOME HEALTH OF RURAL TEXAS, INC.	75-2374091
84	HOME HEALTH SERVICES, INC.	87-0494759
85	HOMECARE HOLDINGS, INC.	65-0837269
86	HORIZON HEALTH CARE SERVICES, INC.	76-0456316
87	HOSPICE FAMILY CARE, INC.	86-0710921
88	HOUSE CALL DOCTORS, INC.	20-3811538
89	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
90	HUMANA AT HOME (DALLAS), INC.	75-2739333
91	HUMANA AT HOME (HOUSTON), INC.	76-0537878
92	HUMANA AT HOME (SAN ANTONIO), INC	01-0766084
93	HUMANA AT HOME (TLC), INC.	75-2600512
94	HUMANA AT HOME 1, INC.	65-0274594
95	HUMANA AT HOME, INC.	13-4036798
96	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
97	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
98	HUMANA BENEFIT PLAN OF TEXAS, INC.	75-2043865
99	HUMANA DENTAL COMPANY	59-1843760
100	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC.	80-0072760
101	HUMANA DIRECT CONTRACTING ENTITY, INC.	85-3099097
102	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
103	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
104	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
105	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235

106	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
107	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
108	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
109	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
110	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632
111	HUMANA HEALTH PLAN, INC.	61-1013183
112	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
113	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
114	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
115	HUMANA INSURANCE COMPANY	39-1263473
116	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
117	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
118	HUMANA MARKETPOINT, INC.	61-1343508
119	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
120	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
121	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
122	HUMANA MEDICAL PLAN, INC.	61-1103898
123	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
124	HUMANA PHARMACY, INC.	61-1316926
125	HUMANA REAL ESTATE COMPANY	20-1724127
126	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
127	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
128	HUMANADENTAL INSURANCE COMPANY	39-0714280
129	HUMANADENTAL, INC.	61-1364005
130	HUMCO, INC.	61-1239538
131	HUM-E-FL, INC.	61-1383567
132	INDEPENDENT CARE HEALTH PLAN	39-1769093
133	INTEGRACARE HOLDINGS, INC.	20-8781607
134	INTEGRACARE HOME HEALTH SERVICES, INC.	75-2865632
135	INTEGRACARE INTERMEDIATE HOLDINGS, INC.	20-8781715
136	ISIDORA'S HEALTH CARE, INC.	65-1285069
137	KAH DEVELOPMENT 16, INC.	87-0548601
138	KENTUCKY HOMECARE HOLDINGS, INC.	82-3695166
139	KENTUCKY HOMECARE PARENT INC.	82-3986306
140	KSOC HOLDINGS, INC.	80-0766080
141	LOVING PEACE HOSPICE, INC.	47-1818578
142	MANAGED CARE INDEMNITY, INC.	61-1232669
143	MED. TECH. SERVICES OF SOUTH FLORIDA, INC.	65-0277280
144	MEDICAL ADVOCATE HEALTHCARE SERVICES CORPORATION	27-2932981
145	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
146	MED-TECH SERVICES OF DADE, INC.	65-1033439
147	MED-TECH SERVICES OF PALM BEACH, INC.	65-0644307
148	METCARE OF FLORIDA, INC.	65-0879131
149	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
150	MISSOURI HOME CARE OF ROLLA, INC.	43-1317147
151	NEW CENTURY HOSPICE, INC.	20-5435710
152	NEW YORK HEALTHCARE SERVICES, INC.	22-2695367
153	NURSING CARE-HOME HEALTH AGENCY, INC.	55-0633030

154	ODYSSEY HEALTHCARE HOLDING COMPANY	75-2925311
155	ODYSSEY HEALTHCARE MANAGEMENT, LP	75-2923658
156	ODYSSEY HEALTHCARE OPERATING A, LP	75-2752908
157	ODYSSEY HEALTHCARE, INC.	43-1723043
158	OHS SERVICE CORP.	22-3690699
159	PBM HOLDING COMPANY	61-1340806
160	PBM PLUS MAIL SERVICE PHARMACY, LLC	20-2373204
161	PHH ACQUISITION CORP.	20-5043135
162	PHHC ACQUISITION CORP.	38-3784032
163	PHP COMPANIES, INC.	62-1552091
164	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
165	QC-MEDI NEW YORK, INC.	11-2750425
166	QUALITY CARE - USA, INC.	11-2256479
167	REGENCY HOSPICE OF NORTHWEST FLORIDA, INC.	26-3437769
168	ROHC, L.L.C.	75-2844854
169	SENIOR HOME CARE, INC.	59-3080333
170	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
171	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
172	SHC HOLDING, INC.	42-1699530
173	SOUTHERN NEVADA HOME HEALTH CARE, INC.	87-0494757
174	SOUTHERNCARE HOLDINGS, INC.	48-1288826
175	SOUTHERNCARE, INC.	16-1645414
176	SUN BROOK HOME CARE, LLC	06-1810593
177	SYNERGY HOME CARE-ACADIANA REGION, INC.	72-1487473
178	SYNERGY HOME CARE-CAPITOL REGION, INC.	20-1376846
179	SYNERGY HOME CARE-CENTRAL REGION, INC.	36-4516940
180	SYNERGY HOME CARE-NORTHEASTERN REGION, INC.	72-1178497
181	SYNERGY HOME CARE-NORTHSHORE REGION, INC.	72-1223659
182	SYNERGY HOME CARE-NORTHWESTERN REGION, INC.	72-1431394
183	SYNERGY HOME CARE-SOUTHEASTERN REGION, INC.	72-1429305
184	SYNERGY, INC.	93-3419676
185	TEXAS DENTAL PLANS, INC.	74-2352809
186	THE AMERICAN HEARTLAND HOSPICE CORP.	43-1697602
187	THE DENTAL CONCERN, INC.	52-1157181
188	THE HOME OPTION, LLC	26-2527353
189	THE HOME TEAM OF KANSAS LLC	74-3052911
190	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
191	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
192	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105
193	US HOUSE CALL PRACTITIONERS, INC.	47-2064816
194	VAN WINKLE HOME HEALTH CARE, INC.	62-1669388
195	VOYAGER HOME HEALTH, INC.	26-1501792
196	VOYAGER HOSPICECARE, INC.	20-1173787

6. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2021 and 2020 are summarized as follows:

	2021	2020
Balance at January 1,	$ 3,291,927,287	$ 2,440,353,699
Health care receivables	(897,139,271)	(875,408,931)
Balance at January 1, net of health care receivables	2,394,788,016	1,564,944,768
Benefits incurred and loss adjustment expenses related to		
Current year	26,030,424,462	24,484,225,543
Prior year	(412,620,355)	(103,937,418)
	25,617,804,107	24,380,288,125
Benefits and loss adjustment expenses paid related to		
Current year	24,110,712,965	22,105,141,890
Prior year	1,898,590,976	1,445,302,987
	26,009,303,941	23,550,444,877
Balance at December 31,	3,139,407,842	3,291,927,287
Health care receivables	(1,136,119,660)	(897,139,271)
Balance at December 31, net of health care receivables	$ 2,003,288,182	$ 2,394,788,016

Benefits and loss adjustment expenses payable, net of healthcare receivables, as of December 31, 2020 were $2,394,788,016. As of December 31, 2021, $1,898,590,976 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $83,576,685 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $412,620,355 favorable prior-year development since December 31, 2020. The decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included in this decrease, the Company experienced $397,050,422 of favorable prior year claim development on retrospectively rated policies. However, the business to which it relates is subject to premium adjustments.

7. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the OCI statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the OCI is the lesser of 10% of total surplus or net gain from operations from the prior year. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $437,500,000 in 2021 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the OCI.

		Dividend or Return of Capital Amount		
		Ordinary	Extraordinary	Date Paid
Dividend		$ -	$ 750,000,000	April 20, 2021
	Total paid in 2021	$ -	$ 750,000,000	
Dividend		$ 300,000,000	$ -	April 7, 2020
Dividend		-	650,000,000	December 21, 2020
	Total paid in 2020	$ 300,000,000	$ 650,000,000	

8. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Wisconsin has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $1,131,660,593 or the Company, under the discretion of the Commissioner of the OCI, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Wisconsin which require a minimum capital and surplus level of $3,969,891,808 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $4,113,959,939 and $4,375,363,823 as of December 31, 2021 and 2020, respectively.

9. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $2,217,578 and $2,099,339 for the years ended December 31, 2021 and 2020, respectively.

Employees of the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2021 and 2020 total allocated expenses associated with these plans were $32,193,280 and $32,774,049, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2021 and 2020 were $(1,891,406,909) and $(666,086,637), respectively, which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These amounts are net of fees received for services provided to wholly owned subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as

required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 4, which were $99,671,824 and $433,700,804 for the years ended December 31, 2021 and 2020, respectively. These amounts are net of fees received for services provided to wholly owned subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates.The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $265,908,400 and $183,694,631 due from Humana at December 31, 2021 and 2020, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

In the ordinary course of business, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(n) for further consideration of related pharmacy rebates. The Company had $17,735,047,831 and $16,940,564,801 of administrative service and prescription costs in 2021 and 2020, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(l).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $3,813,377,511 and $3,828,375,734 of prescription costs in 2021 and 2020, respectively, with Humana Pharmacy, Inc.

The Company has an intercompany reinsurance agreement with its subsidiary HICK. Under the terms of the contract, the Company cedes business including all of it group life, specified disease, disability income, and accident insurance business. For the years ended December 31, 2020 and 2019 there were $48,194,987 and $48,245,098 premiums ceded, respectively, related to this agreement.

The Company entered into a mortgage agreement with Humana on property held by the Company effective February 1, 1999, for $8,550,000 plus accrued interest. The note bears interest only at the rate of 6.65%. The principal and accrued interest amounts were originally due and payable to the Company on January 31, 2009, however, the due date was extended to January 31, 2023. The Company carries this note at book value of $8,550,000.

The Company received no capital contributions in the years ended December 31, 2021 or 2020.

10. Employee Benefit Plans

The Company's employees are eligible to participate in the Humana Retirement Savings Plan (the Plan), a defined contribution plan, sponsored by Humana. The Plan maintains two accounts, the Savings Account and the Retirement Account. Humana's total contributions paid to the Plan were $257,039,906 and $233,856,665 for the years ended December 31, 2021 and 2020, respectively. Of these contributions, the Company contributed $140,382,978 and $123,082,595 during 2021 and 2020, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses. As of December 31, 2021 and 2020, the fair market value of the Humana Retirement Savings Plan's assets were $7,333,284,462 and $6,280,051,531, respectively.

11. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to six years. Operating lease rental payments charged to expenses for the years ended December 31, 2021 and 2020 was $42,673,931 and $21,685,077, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

In 2020 the Company terminated lease agreements early resulting in the recognition of a liability included within accounts payable and accrued expenses within the accompanying statements of admitted assets, liabilities and surplus. The following table includes the leases terminated and the related liability remaining at December 31, 2021 and 2020:

	2021	2020
Tempe Commerce Center	$ -	$ 170,098
Irvine CA KMG Office	-	48,522
Total liability	$ -	$ 218,620

Future minimum rental payments required under operating leases as of December 31, 2021, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,	
2022	$ 39,490,175
2023	31,975,084
2024	26,962,941
2025	24,908,073
2026	6,379,806
Thereafter	7,668,620
Total minimum lease payments	$ 137,384,699

12. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $26,287,208,273 and $26,181,957,434 for the years ended December 31, 2021 and 2020, respectively. The loss of

the Contracts (which are generally renewed annually) or significant changes in the Medicare Advantage and Prescription Drug Plan programs as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2022, and all product offerings filed with CMS for 2022 have been approved.

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

CMS is phasing-in the process of calculating risk scores using diagnoses data from the RAPS to diagnoses data from the EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2021, 75% of the risk score was calculated from claims data submitted through EDS. CMS will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on the Company's results of statutory statements of revenue and expenses, changes in surplus or cash flows.

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for payment years 2012, 2014 and 2015. CMS completed its RADV contract level audit of the 2012 payment year, but has not yet provided the results.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2016. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also

result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus or cash flows.

The Company will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

b. **COVID-19:** The emergence and spread of the novel coronavirus, or COVID-19, beginning in the first quarter of 2020, has impacted the Company's business. During periods of increased incidences of COVID-19, there was a reduction in non-COVID-19 hospital admissions and lower overall healthcare system consumption that decreased utilization. Likewise COVID-19 treatment and testing costs increased utilization. The significant disruption in utilization during 2020 also impacted the Company's ability to implement clinical initiatives to manage health care costs and chronic conditions of its members, and appropriately document their risk profiles, and, as such, significantly affected 2021 revenue under the risk adjustment payment model for MA plans. Finally, changes in utilization patterns and actions taken in 2020 and 2021 as a result of the COVID-19 pandemic, including the suspension of certain financial recovery programs for a period of time and shifting the timing of claim payments and provider capitation surplus payments, impacted claim reserve development and operating cash flows for 2020 and 2021.

c. **Legal Proceedings:** During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus and cash flows, and may also affect the Company's reputation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided Humana's legal counsel with an information request concerning Humana's Medicare Part C risk adjustment practices. The request relates to Humana's oversight and submission of risk adjustment data generated by providers in its MA network, as well as to its business and compliance practices related to risk adjustment data generated by its providers and by Humana, including medical record reviews conducted as part of its data and payment accuracy compliance

efforts, the use of health and well-being assessments, and fraud detection efforts. Humana believes that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of MA plans, providers and vendors. Humana continues to cooperate with the Department of Justice. These matters are expected to result in additional qui tam litigation.

As previously disclosed, on January 19, 2016, an individual filed a qui tam suit captioned *United States of America ex rel. Steven Scott v. Humana, Inc.,* in United States District Court, Central District of California, Western Division. The complaint alleges certain civil violations by Humana in connection with the actuarial equivalence of the plan benefits under Humana's Basic PDP plan, a prescription drug plan offered by it under Medicare Part D. The action seeks damages and penalties on behalf of the United States under the False Claims Act. The court ordered the qui tam action unsealed on September 13, 2017, so that the relator could proceed, following notice from the U.S. Government that it was not intervening at that time. On January 29, 2018, the suit was transferred to the United States District Court, Western District of Kentucky, Louisville Division. Humana substantially completed discovery with the relator who has pursued the matter on behalf of the United States following unsealing. On March 31, 2022, the Court denied the parties' Motions for Summary Judgement. Humana takes seriously its obligations to comply with applicable CMS requirements and actuarial standards of practice, and continue to vigorously defend against these allegations.

d. **Economic Risks:** General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. **Securities & Credit Markets Risks:** Ongoing volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or credit related impairments may be recorded in future periods.

f. **Penn Treaty:** Penn Treaty is a financially distressed unaffiliated long-term care insurance company. On March 1, 2017, the Pennsylvania Commonwealth Court approved the liquidation of Penn Treaty. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, the Company may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as the Company. This court ruling triggered a guaranty fund assessment for the Company in the first quarter of 2017. Based on current information, the assessment is estimated at approximately $26,021,842 with a remaining unpaid balance as of December 31, 2021 of $7,846,662 included in accounts payable and accrued expenses in the accompanying statements of admitted assets, liabilities and surplus. The Company has also recognized an asset for premium tax credits associated with the assessment at December 31, 2021 and 2020 of $19,156,620 and $10,174,786, respectively, which are expected to be realized over the next 20 years. While the ultimate payment timing and associated recovery is currently unknown, the Company anticipates that the majority of the assessments will be paid within the next 5 years.

The below table reconciles the asset for premium tax credits associated with the assessment at December 31, 2020 to those reported at December 31, 2021.

a.) Assets recognized from paid and accrued premium tax offsets and policy surcharges prior year-end	$	10,174,786
b.) Decreases current year:		
Credits Used		2,304,190
Misc. Adjustments		(740,386)
c.) Increases current year:		-
d.) Assets recognized from paid and accrued premium tax offsets and policy surcharges current year-end	$	8,610,982

Discount rate applied: 3.50%

The Undiscounted and Discounted Amount of the Guaranty Fund assessments and Related Assets by Insolvency:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty	$ 36,951,016	$ 26,021,842	$ 27,202,400	$ 19,156,620

Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency:

	Payables			Recoverables		
Name of the Insolvency	Number of Jurisdictions	Range of Years	Weighted Average Number of Years	Number of Jurisdictions	Range of Years	Weighted Average Number of Years
Penn Treaty	50 states	1 to 70 years	11.96 years	39 states	1 to 20 years	8.1 years

13. Uninsured Plans

Information for the year ended December 31, 2021 regarding the profitability of ASO plans and the uninsured portion of partially insured plans for which the Company provides administrative services were as follows:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$ (1,565,832)	$ (7,321,936)	$ (8,887,768)
Total net other income or expenses (including interest paid to or received from plans)	(835)	(3,907)	(4,742)
Net gain or (loss) from operations	$ (1,566,667)	$ (7,325,843)	$ (8,892,510)
Total claim payment volume	89,073,342	416,513,077	505,586,420

As of December 31, 2021, the Company has recorded a receivable from CMS of $1,451,968,801 related to the cost share and reinsurance components of administered Medicare products and a

receivable from ASO customers of $28,346,952. The Company has recorded receivables from the following payors whose account balance are greater than 10% of the Company's accounts receivable from uninsured accident and health plans or $10,000:

	2021
OSF Healthcare	$ 645,602
Michiana Area Electrical Workers Local 153	470,306
Louisville Metro Government	417,712

	2020
Maricopa Community College	$ 1,103,885
Excela Health	623,523

Supplemental Investment Information

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2021

Of the **Humana Insurance Company** Insurance Company
Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436
NAIC Group Code 0119 NAIC Company Code 73288 Employer's ID Number 39-1263473

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 4 of the statement of admitted assets, liabilities and surplus. $8,917,292,835.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	Federal National Mortgage Association	MBS	$ 687,866,536	7.71%
2.02	Federal Home Loan Mortgage Corporation	CMO MBS	239,469,931	2.69%
2.03	Bank of America Corporation	Bonds	51,281,383	0.58%
2.04	Apple Inc.	Bonds	48,594,986	0.54%
2.05	Wells Fargo & Company	Bonds	46,869,129	0.53%
2.06	Cd 2017-Cd3	MBS	46,513,029	0.52%
2.07	Morgan Stanley	Bonds	45,096,208	0.51%
2.08	T-Mobile USA Inc.	Bonds	40,182,987	0.45%
2.09	Verizon Communications Inc.	Bonds	36,716,079	0.41%
2.10	Truist Financial Corporation	Bonds	32,254,475	0.36%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 2,911,086,376	32.65%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	1,021,086,890	11.45%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	271,770,154	3.05%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	16,239,428	0.18%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	157,809	0.00%	3.12	P/RP-6	-	0.00%

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?	Yes [ ]	No [X]
4.02	Total admitted assets held in foreign investments.	$ 446,038,290	5.00%
4.03	Foreign-currency-denominated investments.	-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency	-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

				1	2
5.01	Countries rated NAIC - 1		$	407,015,480	4.56%
5.02	Countries rated NAIC - 2			39,022,810	0.44%
5.03	Countries rated NAIC - 3 or below			-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

				1	2
	Countries rated NAIC - 1:				
6.01	Country:	Cayman Islands	$	216,213,151	2.42%
6.02	Country:	Switzerland		29,240,000	0.33%
	Countries rated NAIC - 2				
6.03	Country:	Mexico	$	15,549,083	0.17%
6.04	Country:	Peru		13,815,199	0.15%
	Countries rated NAIC - 3 or below				
6.05	Country:		$	-	0.00%
6.06	Country:			-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1	2		3	4
	Issuer	**NAIC Rating**			
10.01	ArcelorMittal	2FE	$	20,153,939	0.23%
10.02	Park Avenue Institutional Advisers CLO Ltd 2017-1	1FE		19,650,000	0.22%
10.03	Mizuho Financial Group Inc.	1FE		17,930,000	0.20%
10.04	Ardagh Metal Packaging Finance plc	3FE		16,131,864	0.18%
10.05	Credit Suisse Group AG	2FE		15,840,000	0.18%
10.06	CBAM 2017-1 Ltd.	1FE		14,837,705	0.17%
10.07	Carlyle Global Market Strategies CLO 2014-3-R Ltd	1FE		14,091,742	0.16%
10.08	Neuberger Berman Loan Advisers Clo 26 Ltd.	1FE		13,840,000	0.16%
10.09	Commonwealth Bank of Australia	2FE		13,755,000	0.15%
10.10	UBS Group AG	1FE		13,400,000	0.15%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.			
11.02	Total admitted assets held in Canadian Investments	$	-	0.00%
11.03	Canadian-currency-denominated investments		-	0.00%
11.04	Canadian-denominated insurance liabilities		-	0.00%
11.05	Unhedged Canadian currency exposure		-	0.00%

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.			
	1		**2**	**3**
12.02	Aggregate statement value of investments with contractual sales restrictions	$	-	0.00%
	Largest 3 investments with contractual sales restrictions			
12.03			-	0.00%
12.04			-	0.00%
12.05			-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]
	If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.	

	1 Name of Issuer	2	3
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	JP Morgan	$ 53,775,364	$ 53,775,364	$ -
14.07	Wells Fargo Funds Trust - Treasury Plus Money Market Fund	55,015	55,015	-
14.08	First American Funds Inc. - Treasury Obligations Fund	8,869	8,869	-
14.09	JPMorgan Trust II - JPMorgan U.S. Treasury Plus Money Market Fund	7,035	7,035	-
14.10	BlackRock Liquidity Funds - T-Fund	4,702	4,702	-
14.11	Fidelity Colchester Street Trust - Treasury Portfolio	4,637	4,637	-
14.12	BlackRock Liquidity Funds - Treasury Trust Fund	4,481	4,481	-
14.13		-	-	-
14.14		-	-	-
14.15		-	-	-

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1	2	3
	Type (Residential, Commercial, Agricultural)		
16.02		$ -	0.00%
16.03		-	0.00%
16.04		-	0.00%
16.05		-	0.00%
16.06		-	0.00%
16.07		-	0.00%
16.08		-	0.00%
16.09		-	0.00%
16.10		-	0.00%
16.11		-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description		
	1	2	3
18.02		$ -	0.00%
18.03		-	0.00%
18.04		-	0.00%
18.05		-	0.00%
18.06		-	0.00%

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:		
		2	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description		
	1	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	0	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Insurance Company
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2021

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1 Amount	2 Percentage	1 Amount	2 Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 14,504,506	0.29%	$ 14,504,506	0.29%
1.02	All other governments	23,473,727	0.46%	23,473,727	0.46%
1.03	U.S. states, territories and possessions, etc. guaranteed	10,056,786	0.20%	10,056,786	0.20%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	43,516,707	0.86%	43,516,707	0.86%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	1,235,895,362	24.46%	1,235,895,362	24.46%
1.06	Industrial and miscellaneous	2,878,348,569	56.95%	2,878,348,569	56.95%
1.07	Hybrid securities	14,475,000	0.29%	14,475,000	0.29%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	4,220,270,657	83.51%	4,220,270,657	83.51%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	12,429,100	0.25%	12,429,100	0.25%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	742,443,529	14.69%	742,443,529	14.69%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	754,872,629	14.94%	754,872,629	14.94%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	8,550,000	0.17%	8,550,000	0.17%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total valuation allowance	-	0.00%	-	0.00%
4.06	Total mortgage loans	8,550,000	0.17%	8,550,000	0.17%
5. Real estate					
5.01	Properties occupied by company	21,120	0.00%	21,120	0.00%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	21,120	0.00%	21,120	0.00%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	18,820,156	0.37%	18,820,156	0.37%
6.02	Cash equivalents	84,740	0.00%	84,740	0.00%
6.03	Short-term investments	69,999	0.00%	69,999	0.00%
6.04	Total cash, cash equivalents and short-term investments	18,974,895	0.37%	18,974,895	0.37%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		49,969,673	0.99%	49,969,673	0.99%
10. Receivables for securities		810,000	0.02%	810,000	0.02%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 5,053,468,974	100.00%	$ 5,053,468,974	100.00%

Humana Insurance Company

(a wholly owned subsidiary of CareNetwork, Inc., a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2020 and 2019

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Report of Independent Auditors

To the Board of Directors of Humana Insurance Company

We have audited the accompanying statutory financial statements of Humana Insurance Company, which comprise the statutory statements of admitted assets, liabilities and surplus as of December 31, 2020 and 2019, and the related statutory statements of revenue and expenses and changes in surplus, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Insurance Department of the state of Wisconsin. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by the Company on the basis of the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

The effects on the financial statements of the variances between the statutory basis of accounting described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter discussed in the "Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles" paragraph, the financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company as of December 31, 2020 and 2019, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities and surplus of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for the years then ended, in accordance with the accounting practices prescribed or permitted by the Insurance Department of the State of Wisconsin described in Note 2.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the statutory-basis financial statements taken as a whole. The supplemental investment risk interrogatories and summary investment schedule (collectively, the "supplemental schedules") of the Company, as of December 31, 2020 and for the year then ended are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. The supplemental schedules are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. The supplemental schedules have been subjected to the auditing procedures applied in the audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplemental schedules are fairly stated, in all material respects, in relation to the statutory-basis financial statements taken as a whole.

PricewaterhouseCoopers LLP

Louisville, Kentucky
April 29, 2021

Humana Insurance Company
Statements of Admitted Assets, Liabilities and Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Admitted Assets		
Cash and invested assets		
Bonds	$ 4,107,067,395	$ 3,576,873,323
Investment in subsidiaries	742,129,787	675,991,500
Mortgage notes receivable from Humana Inc.	8,550,000	8,550,000
Real estate occupied by the Company	10,899,516	12,321,647
Receivable for securities	35,000	10,000
Short-term investments	167,389,639	629,939,908
Total invested assets	5,036,071,337	4,903,686,378
Cash	126,828,448	58,058,892
Cash equivalents	1,180,710,045	883,095,733
Total cash and invested assets	6,343,609,830	5,844,841,003
Premiums receivable	548,604,973	418,268,039
Investment income due and accrued	24,038,784	26,684,338
Amounts receivable relating to uninsured plans	1,129,286,621	494,935,759
Reinsurance receivable	5,765,945	6,174,460
Health care and other receivables	923,081,452	867,606,543
Current federal income tax recoverable	66,243,478	-
Net deferred tax assets	130,573,948	93,263,946
Electronic data processing equipment and software, less accumulated depreciation of $57,073,508 and $46,614,589 in 2020 and 2019, respectively	38,615,372	46,072,096
Receivable from Humana Inc.	183,694,631	192,687,773
Total admitted assets	$ 9,393,515,034	$ 7,990,533,957
Liabilities		
Benefits and loss adjustment expenses payable	$ 3,291,927,287	$ 2,440,353,699
Aggregate health policy reserves	644,149,128	391,164,583
Aggregate health claim reserves	821,860	740,000
Advance premiums	154,085,273	100,273,263
Accounts payable and accrued expenses	918,816,129	911,059,382
Funds held under reinsurance treaties	8,351,534	6,866,237
Current federal income tax payable	-	10,671,798
Total liabilities	5,018,151,211	3,861,128,962
Surplus		
Common stock, $8.00 par value; 15,000,000 shares authorized; 1,104,167 shares issued and outstanding	8,833,336	8,833,336
Special surplus - projected HCRL fee assessment	-	510,143,497
Paid-in surplus	2,105,092,362	2,105,092,362
Unassigned surplus	2,261,438,125	1,505,335,800
Total surplus	4,375,363,823	4,129,404,995
Total liabilities and surplus	$ 9,393,515,034	$ 7,990,533,957

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Revenue and Expenses
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Earned premiums, net of reinsurance	$ 28,877,184,688	$ 26,445,947,450
Expenses		
Benefits incurred and loss adjustment expenses	24,380,288,125	22,935,211,175
Selling, general and administrative expenses	3,184,891,087	2,420,160,393
Changes in aggregate health policy reserves	80,887,629	(2,834,924)
Total expenses	27,646,066,841	25,352,536,644
Net underwriting gain	1,231,117,847	1,093,410,806
Net investment income	292,447,541	361,424,418
Net realized capital gains on investments (net of capital gains tax of $19,620,490 and $3,010,673, respectively)	738,848	11,325,866
Net other income (expense)	1,299,783	(1,474,837)
Income before federal income tax expense	1,525,604,019	1,464,686,253
Federal income tax expense	398,875,632	280,022,849
Net income	$ 1,126,728,387	$ 1,184,663,404

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Changes in Surplus
Statutory Basis of Accounting
December 31, 2020 and 2019

	Common Stock					
	Shares	Amount	Special Surplus	Paid-in Surplus	Unassigned Surplus	Total
Balances at January 1, 2019	1,104,167	$ 8,833,336	$ 1,106,711	$ 2,085,107,576	$ 1,625,625,257	$ 3,720,672,880
Net income	-	-	-	-	1,184,663,404	1,184,663,404
Projected HCRL fee assessment	-	-	510,143,497	-	(510,143,497)	-
Amortization of gain on reinsurance	-	-	(1,106,711)	-	-	(1,106,711)
Change in net unrealized capital loss, less capital gains tax of $0	-	-	-	-	(121,585,946)	(121,585,946)
Change in net deferred income taxes	-	-	-	-	21,574,734	21,574,734
Change in nonadmitted assets	-	-	-	-	(19,798,152)	(19,798,152)
Forgiveness of payable from Humana Inc.	-	-	-	19,984,786	-	19,984,786
Dividends or return of capital paid	-	-	-	-	(675,000,000)	(675,000,000)
Balances at December 31, 2019	1,104,167	8,833,336	510,143,497	2,105,092,362	1,505,335,800	4,129,404,995
Net income	-	-	-	-	1,126,728,387	1,126,728,387
HCRL fee moratorium	-	-	(510,143,497)	-	510,143,497	-
Change in net unrealized capital gain, less capital gains tax of $0	-	-	-	-	66,297,981	66,297,981
Change in net deferred income taxes	-	-	-	-	42,171,191	42,171,191
Change in nonadmitted assets	-	-	-	-	(39,238,731)	(39,238,731)
Dividends or return of capital paid	-	-	-	-	(950,000,000)	(950,000,000)
Balances at December 31, 2020	1,104,167	$ 8,833,336	$ -	$ 2,105,092,362	$ 2,261,438,125	$ 4,375,363,823

The accompanying notes are an integral part of these statutory basis financial statements.

Humana Insurance Company
Statements of Cash Flows
Statutory Basis of Accounting
December 31, 2020 and 2019

	2020	2019
Cash flows from operations		
Premiums collected, net of reinsurance	$ 28,971,886,654	$ 26,701,434,846
Net investment income received	142,213,600	189,060,289
Benefits paid	(22,495,260,427)	(21,713,676,858)
Selling, general and administrative expenses paid	(4,845,676,344)	(3,658,909,389)
Federal income taxes paid	(495,411,398)	(252,371,627)
Net cash from operations	1,277,752,085	1,265,537,261
Cash flows from investments		
Proceeds from investments sold or matured	1,735,579,294	1,760,563,141
Cost of investments acquired	(2,079,870,427)	(1,590,766,585)
Net cash (used for) from investments	(344,291,133)	169,796,556
Cash flows from financing and miscellaneous sources		
Dividends or returns of capital paid	(950,000,000)	(675,000,000)
Other cash applied	(79,627,354)	(108,557,055)
Net cash used for financing and miscellaneous sources	(1,029,627,354)	(783,557,055)
Net change in cash, cash equivalents and short-term investments	(96,166,400)	651,776,762
Cash, cash equivalents and short-term investments		
Beginning of year	1,571,094,534	919,317,771
End of year	$ 1,474,928,132	$ 1,571,094,533

The accompanying notes are an integral part of these statutory basis financial statements.

1. Reporting Entity

Humana Insurance Company (the Company), a wholly owned subsidiary of CareNetwork Inc., a wholly owned subsidiary of Humana Inc. (Humana), is a life, accident, and health insurance company domiciled in the state of Wisconsin and is authorized to sell life, accident and health products therein and in 49 states including the District of Columbia and the U.S. Virgin Islands. The Company is subject to regulation by the federal government, the Wisconsin Office of the Commissioner of Insurance (the OCI) and the insurance departments of the states in which it is licensed. State regulations require the Company to maintain certain minimum amounts of surplus as discussed in Note 8, and limit the payment of dividends or returns of capital to shareholders as discussed in Note 7.

The Company offers coordinated health and pharmacy insurance coverage and related services through a variety of plans for government-sponsored programs and employer groups. Under the Company's federal government contracts with the Centers for Medicare and Medicaid Services (CMS), the Company provides health and pharmacy insurance coverage to Medicare eligible members, as further discussed in Note 12(a).

As part of the Company's individual Medicare Advantage products, it also offers Dual Eligible Special Needs (D-SNP) plans. In connection with offering a D-SNP plan in a particular state, the Company is required to enter into a special coordinating contract with the applicable state Medicaid agency.

The operating results of companies in the insurance industry have historically been subject to significant fluctuations due to competition, economic conditions, interest rates, investment performance, maintenance of insurance ratings, renewal of contracts and other factors.

2. Summary of Significant Accounting Policies

The preparation of the Company's financial statements and accompanying notes requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

The more significant accounting policies of the Company are as follows:

a. Basis of Presentation: The statutory financial statements and accompanying notes are prepared in conformity with accounting practices prescribed or permitted by the OCI, which vary in some respects from accounting principles generally accepted in the United States of America (GAAP). The principle differences include:

i. Certain assets designated as nonadmitted assets as described in Note 2(s), are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus, whereas under GAAP, such amounts would be reported as assets;

ii. Bonds and short-term investments are generally carried at amortized cost, whereas under GAAP, such investments would be carried at fair value with related unrealized gains and losses, net of deferred taxes, being reported as a component of equity;

iii. Cash overdraft balances are recorded as a reduction to cash, whereas under GAAP, overdraft balances would be classified as liabilities;

iv. Deferred taxes are provided for only the federal income tax consequences of temporary differences, whereas under GAAP, such deferred taxes would be provided for both the federal and state income tax consequences of such temporary differences;

v. The amount of admitted deferred tax assets is limited, whereas under GAAP, deferred tax assets would be recorded to the extent they will more likely than not be realized. In addition, the change in deferred tax assets and liabilities is recorded directly to unassigned surplus, whereas under GAAP, the change in deferred tax assets and liabilities is recorded as a component of the income tax provision within the income statement;

vi. Policy acquisition costs are charged to operations as incurred, whereas under GAAP, to the extent recoverable from future policy revenues, they would be deferred and amortized over the terms of the related policies;

vii. Policy and contract liabilities are reported net of reinsurance ceded amounts and any gains from reinsurance transactions are included as a component of surplus, whereas under GAAP, assets and liabilities related to reinsurance ceded contracts are reported on a gross basis and reinsurance transaction gains are reported as a liability;

viii. Investments in subsidiaries are carried at their underlying statutory equity value with changes in value being recorded directly to surplus, whereas under GAAP, these subsidiaries would be consolidated;

ix. Administrative service fees received from customers on an uninsured basis are deducted from general administrative expenses, whereas under GAAP, these administrative fees are reported as revenue within the income statement;

x. Comprehensive income disclosures required by GAAP are omitted; and

xi. The statutory basis statements of cash flow reconcile cash, cash equivalents, and short-term investments with maturity dates of one year or less at the time of acquisition. Under GAAP, the statement of cash flow reconciles the corresponding captions of cash and cash equivalents with maturities of three months or less. In addition, there are classification differences within the presentation of the cash flow categories between GAAP and statutory reporting and a reconciliation of net earnings to net cash provided by operations is not provided.

xii. Under the statutory basis of accounting, rent expense is recorded when incurred with no related assets or liability balances, whereas under GAAP lessees are required to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income.

The OCI adopted the National Association of Insurance Commissioners (NAIC) *Accounting Practices and Procedures Manual - Effective January 1, 2001* (Codification) and *Statements of Statutory Accounting Principles* (SSAP), incorporated thereafter. The OCI has adopted the Codification as a component of its prescribed or permitted practices. The Commissioner of Insurance has the right to permit other specific practices that deviate from prescribed practices. No deviations from the Codification currently exist.

b. Health Care Reform: The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which the Company collectively refers to as the Health

Care Reform Law (HCRL) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the HCRL include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to MA premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the HCRL established insurance industry assessments, including an annual health insurance industry fee. The annual health insurance industry fee, which is not deductible for income tax purposes and significantly increases the Company's effective tax rate, was suspended in 2019, resumed for calendar year 2020 and, under current law, has been permanently repealed beginning in calendar year 2021. The annual health insurance industry fee levied on the insurance industry was $15.5 billion in 2020.

The 2020 annual health insurance industry fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that was written during the preceding calendar year. A segregation was recorded within special surplus for the annual health insurance industry fee related to the 2019 data year for the 2020 fee. The 2020 health insurance industry fee was paid September 30, 2020. The impact of the annual health insurance industry fee on the Company's operations as of December 31, 2020 and 2019 were as follows:

	2020	2019
HCRL fee assessment payable	$ -	$ 510,143,497
HCRL fee assessment paid	464,411,417	-
Premium written subject to HCRL 9010 assessment	-	25,663,900,250
Total Adjusted Capital Level before surplus adjustment	4,376,071,991	4,130,039,768
Total Adjusted Capital Level after surplus adjustment	4,376,071,991	3,619,896,271
Authorized Control Level after surplus adjustment	1,079,681,341	1,014,950,193

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

Additionally, potential legislative changes or judicial determinations, including activities to repeal or replace the HCRL or declare all or certain portions of the HCRL unconstitutional, create uncertainty for the Company's business and the Company cannot predict when or in what form, such legislative changes or judicial determination may occur.

c. **Cash, Cash Equivalents and Short-Term Investments:** The Company carries cash equivalents at cost, which approximates fair value. Cash equivalents are highly liquid financial instruments with an original maturity of three months or less.

Short-term investments are valued and classified in accordance with methods prescribed by the NAIC's Securities Valuation Office (SVO). Short-term investments include investments with an NAIC designated rating of 1 and a maturity of twelve months or less from the date of purchase. Short-term investments are recorded at amortized cost. The carrying value of short-term investments approximates fair value due to the short-term maturities of the investments.

Under the Company's cash management system, checks issued but not presented to banks frequently result in overdraft balances for accounting purposes, and, if applicable, are included in cash and cash equivalents on the statements of admitted assets, liabilities and surplus.

d. **Investments:** Bonds, including loan-backed and structured securities, with an NAIC designated rating of 1 or 2 are carried at amortized cost, with all other bonds being recorded at the lower of amortized cost or fair value.

Amortization of bond premium or discount is computed using the scientific interest method.

The Company regularly evaluates the investment securities for impairment. For all securities other than loan-backed and structured securities, the determination of whether the impairment is considered other-than-temporary is dependent upon whether a decline in the fair value of the investment is noninterest related or interest related. The Company considers noninterest related factors such as the extent to which the fair value has been less than cost, adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds and the intent and ability of the Company to retain its investment in the issuer for a period of time sufficient to allow for any anticipated recovery in fair value. An interest-related impairment is deemed other-than-temporary when the Company has the intent to sell, at the date of the statutory financial statements, an investment before recovery of cost of the investment. The Company also considers whether its cash or surplus requirements and contractual or regulatory obligations dictate that the investment may need to be sold before forecasted recovery occurs. If and when a determination is made that a decline in fair value below the carrying value is other-than-temporary, a realized loss is recorded to the extent that the fair value of the investment is below its carrying value.

For loan-backed and structured securities where the securities' fair value is less than the amortized cost, and either (1) the insurer has the intent to sell the security, or (2) the insurer does not have the intent and ability to retain the security until recovery of its fair value, the Company recognizes an impairment in earnings equal to the difference between the security's fair value and its carrying value. For securities for which the Company does not expect to recover its amortized cost basis but has the intent and ability to hold the security until maturity, the insurer will recognize in earnings a realized loss only for the "noninterest" related decline. The Company evaluates the expected cash flows to be received as compared to amortized cost and determines if a "noninterest" related decline has occurred. In the event of a "noninterest" related decline, only the amount of the impairment associated with the "noninterest" related decline is recognized currently in income. No loss is recognized for the interest impairment. The Company considers factors such as the extent to which the fair value has been less than cost, adverse conditions

specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security, changes in the quality of the security's credit enhancement, payment structure of the security, changes in credit rating of the security by the rating agencies, failure of the issuer to make a scheduled principal of interest payment on the security, changes in prepayment speeds, cash or surplus requirements and contractual or regulatory obligations in determining whether or not it expects to recover the amortized cost of the security. If the determination is made, based on these factors, that the Company does expect to recover the entire amortized cost of the security, an other-than-temporary impairment has not occurred. Prepayment assumptions for loan-backed and structured securities were obtained from industry market sources.

The Company does not have any investments in an other-than-temporary impairment position at December 31, 2020 or December 31, 2019.

Income from investments is recorded on an accrual basis. For the purpose of determining realized gains and losses, the cost of securities sold is based upon specific identification. Investment income due and accrued over 90 days past due is nonadmitted with the exception of mortgage loans in default. No portion of the investment income due and accrued was nonadmitted at December 31, 2020 or 2019.

For other restricted assets reported in aggregate, the pledged amounts with the OCI and other state departments of insurance were $11,301,477 and $11,038,109, which is 0.12% and 0.14% of gross assets and 0.12% and 0.14% of net admitted assets, at December 31, 2020 and 2019, respectively. These investments, generally U.S. Treasury obligations and money market mutual funds, were on deposit at December 31, 2020 and 2019 to satisfy requirements of regulatory agencies. These assets are included in bonds and cash equivalents in the accompanying statements of admitted assets, liabilities and surplus. These assets are valued and classified in accordance with methods prescribed by the NAIC.

e. Fair Value: In accordance with SSAP No. 100R, *Fair Value Measurements* (SSAP No. 100), fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Company's financial assets carried at fair value have been classified based upon the hierarchy defined in SSAP No. 100. The three tiered hierarchy is defined as follows:

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

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

Level 3 Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions

about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. The Company obtains at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates and prepayment speeds. The Company is responsible for the determination of fair value and as such, the Company performs an analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. The Company's analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by the Company's third party investment adviser. In addition, on a quarterly basis, the Company examines the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations. Based on the Company's internal price verification procedures and review of fair value methodology documentation provided by the third party pricing service, there were no material adjustments to the prices obtained from the third party pricing service during the years ended December 31, 2020 or 2019.

The fair value of financial assets carried at fair value at December 31, 2020 and 2019 were as follows:

	Fair Value Measurements at December 31, 2020			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	$ -	$ 222,629	$ -	$ 222,629
Corporate debt securities	-	12,620,988	-	12,620,988
Total invested assets	$ -	$ 12,843,617	$ -	$ 12,843,617

	Fair Value Measurements at December 31, 2019			
	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
Assets				
Residential mortgage-backed	$ -	$ 294,400	$ -	$ 294,400
Corporate debt securities	-	15,036,478	-	15,036,478
Total invested assets	$ -	$ 15,330,878	$ -	$ 15,330,878

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2020 and 2019 were as follows:

	December 31, 2020					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 5,652,736,110	$ 5,455,167,079	$ 1,092,956,754	$ 4,559,779,356	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 5,661,286,110	$ 5,463,717,079	$ 1,092,956,754	$ 4,559,779,356	$ 8,550,000	$ -

	December 31, 2019					
	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Bonds, short-term investments and cash equivalents	$ 5,163,221,729	$ 5,089,908,964	$ 883,095,733	$ 4,280,125,996	$ -	$ -
Mortgage loans	8,550,000	8,550,000	-	-	8,550,000	-
Total	$ 5,171,771,729	$ 5,098,458,964	$ 883,095,733	$ 4,280,125,996	$ 8,550,000	$ -

f. Real Estate and Long-Lived Assets: Real estate occupied by the Company is carried at the depreciated cost. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from ten to twenty years. Depreciation expense on real estate occupied by the Company was $1,760,633 and $1,944,995 for the years ended December 31, 2020 and 2019, respectively.

The Company periodically reviews long-lived assets, including property and equipment, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in the Company's operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. The Company recognizes an impairment loss based on the excess of the carrying value over the fair value of the asset. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, the Company periodically reviews the estimated lives of all long-lived assets for reasonableness.

g. Investment in subsidiaries: In accordance with SSAP No. 97, *Investments in Subsidiary, Controlled, and Affiliated Entities,* a replacement of SSAP No. 88 (SSAP No. 97), $742,129,787 and $675,991,500 were admitted as investment in subsidiaries at December 31, 2020 and 2019, respectively. The Company owns 100% of the common stock of Humana Employers Health Plan of Georgia, Inc. (HEHPGA), Humana Insurance Company of Kentucky (HICK), and Humana

Health Benefit Plan of Louisiana, Inc. (HHBPLA). The Company accounts for its investment in subsidiaries using the statutory equity method of accounting.

The Company reports an investment in an insurance subsidiary, HHBPLA, for which the audited statutory equity reflects a departure from the NAIC statutory accounting practices and procedures. The Commissioner of Insurance of the State of Louisiana allowed HHBPLA to admit its $719,533 and $775,406 of furniture and equipment used for Health Maintenance Organization operations in 2020 and 2019, respectively, which is not in accordance with NAIC SSAP. Had HHBPLA not been allowed to admit these balances, their ending surplus at December 31, 2020 and 2019 would have been $344,369,369 and $278,859,450, respectively. The Company's risk-based capital would have not triggered a regulatory event had it not used a prescribed or permitted practice.

h. Equipment: Equipment is recorded at cost less accumulated depreciation. Gains and losses on sales or disposals of property and equipment are included in net other income (expense) in the accompanying statements of revenue and expenses. Depreciation expense is computed using the straight-line method over estimated useful lives generally ranging from 3 to 10 years. Depreciation expense, including that related to the nonadmitted portion, was $26,158,063 and $27,087,238 for the years ended December 31, 2020 and 2019, respectively.

Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement. Depreciation expense related to leasehold improvements was $2,129,330 and $1,939,589 for the years ended December 31, 2020 and 2019, respectively.

i. Income Taxes: The amounts recorded as federal income tax expense in the accompanying statements of revenue and expenses represent amounts due to or from Humana in accordance with the tax allocation agreement between the Company and Humana. Any unsettled portion of the federal taxes is recorded as current federal income tax payable or receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets or liabilities and their reported amounts in the statutory financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. The Company also recognizes the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. Deferred tax assets and deferred tax liabilities are further adjusted for changes in the enacted tax rates.

Statutory deferred tax assets (DTAs) are limited to an amount equal to the sum of: (1) federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year; (2) depending on the Company's Authorized Control Level (ACL) Risk Based Capital (RBC) exclusive of the DTA Ratio, the lesser of (a) the amount of gross DTAs expected to be realized within three years after the application of (1) or 15% of surplus, if the ratio is greater than 300%, (b) the amount of gross DTAs expected to be realized within one year after the application of (1) or 10% of surplus, if the ratio is between 200 – 300%, or (c) if the ratio is below 200%, no DTA can be realized; (3) the amount of gross DTAs, after the application of (1) and (2), that can be offset against gross deferred tax liabilities (DTLs). DTAs in excess of these limitations are nonadmitted. At December 31, 2020 and 2019 DTAs of $18,129,081 and $13,267,892, respectively, were nonadmitted.

j. Earned Premiums: Premiums are estimated by multiplying the membership covered under the Company's various contracts by the contractual rates. Premiums are reported as earned in the

period members are entitled to receive services, and are net of retroactive membership adjustments. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. The Company routinely monitors the collectability of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflects any required adjustments in current operations. Premiums received prior to the earned period are recorded as advance premiums.

The Company receives monthly premiums from the federal government according to government specified payment rates and various contractual terms. The Company bills and collects premiums from employer groups and members in its Medicare products monthly. Changes in premium revenues resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for its membership are estimated by projecting the ultimate annual premium and are recognized ratably during the year, with adjustments each period to reflect changes in the ultimate premium.

CMS uses a risk-adjustment model which adjusts premiums paid to MA plans according to health status of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby prospective payments are based on the Company's estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of the Company's enrolled membership. Under the risk-adjustment methodology, all MA plans must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. The Company generally relies on providers, including certain providers in its network who are employees of affiliates of the Company, to code their claim submissions with appropriate diagnoses, which the Company sends to CMS as the basis for the Company's payment received from CMS under the actuarial risk-adjustment model. The Company also relies on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System (RAPS) to diagnoses data from the Encounter Data System (EDS). The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit diagnoses that satisfy those guidelines. For submissions through EDS, CMS requires MA plans to submit all the encounter data and CMS will apply the risk adjustment filtering logic to determine the risk scores. For 2020, 50% of the risk score was calculated from claims data submitted through EDS. CMS increased that percentage to 75% for 2021 and will complete the phased-in transition from RAPS to EDS by using only EDS data to calculate risk scores in 2022.

The amount of net premiums written by the Company in 2020 and 2019 that were subject to retrospective rating features were $27,296,362,970 and $24,976,993,090, respectively, or 94.53% and 94.45%, respectively, of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

In accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84), the Company has recorded receivables from CMS under the risk adjustment model of $318,241,471 and $303,393,822 as of December 31, 2020

and 2019, respectively, which are included in premiums receivable in the accompanying statements of admitted assets, liabilities and surplus.

The Company estimates policyholder rebates by projecting calendar year minimum benefit ratios for the MA, small group and large group markets, as defined by the HCRL using a methodology prescribed by the Department of Health and Human Services (HHS). Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience.

Pursuant to the HCRL, the Company recorded the following amounts at December 31, 2020 and 2019 for policyholder rebates:

	2020					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred (recovered)	$ 4,341,122	$ 3,129,358	$ (1,623,507)	$ 5,846,973	$ 55,177,890	$ 61,024,863
Medical loss ratio rebates paid	-	2,837,212	346,527	3,183,739	14,581,350	17,765,089
Medical loss ratio rebates unpaid	4,341,122	449,866	378,026	5,169,014	109,278,818	114,447,832

	2019					
	Individual	Small Group	Large Group	Total Commercial	Other Categories with Rebates	Total
Medical loss ratio rebates incurred	$ -	$ (1,255,879)	$ 17,870	$ (1,238,009)	$ 55,369,252	$ 54,131,243
Medical loss ratio rebates paid	-	741,888	1,108,205	1,850,093	-	1,850,093
Medical loss ratio rebates unpaid	-	157,720	2,348,060	2,505,780	68,682,278	71,188,058

The amounts recorded for the medical loss rebates incurred are recorded as a reduction of premium in earned premiums in the accompanying statutory statements of revenue and expenses. The medical loss rebates unpaid are included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

There is no impact of any reinsurance assumed or ceded on the medical loss ratio rebate.

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

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as define by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require the Company to refund to CMS a portion of the premiums received. As risk corridor provisions are considered in the Company's overall annual bid process

and in accordance with SSAP No. 66, *Retrospectively Rated Contracts*, (SSAP No. 66), the Company estimates and recognizes an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. The Company records a receivable or payable at the contract level.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which the Company assumes no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with the Company's annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs paid by the Company is made after the end of the year. The HCRL mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while the Company administers the application of these funds.

In accordance with SSAP No. 47, *Uninsured Plans*, (SSAP No. 47), the Company accounts for these subsidies and discounts as a deposit in the accompanying statements of admitted assets, liabilities and surplus and as an operating activity in the accompanying statements of cash flows. The Company does not recognize earned premiums or benefits incurred and loss adjustment expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in the statutory statements of admitted assets, liabilities and surplus in amounts receivable relating to uninsured plans or accounts payable and accrued expenses.

Settlement of the reinsurance and low-income cost subsidies as well as risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. The Company continues to revise its estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data.

The accompanying statements of admitted assets, liabilities and surplus include the following amounts associated with Medicare Part D as of December 31, 2020 and 2019:

	2020		2019	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
Premiums receivable	$ 128,324,320	$ -	$ 3,209,354	$ -
Amounts receivable relating to uninsured plans	-	1,119,108,271	-	482,892,958
Aggregate health policy reserves	(85,986,712)	-	(112,321,409)	-
Accounts payable and accrued expenses	-	(162,274,651)	-	(229,954,566)
Net asset (liability)	$ 42,337,608	$ 956,833,620	$ (109,112,055)	$ 252,938,392

I. **Accounting for the Risk-Sharing Provisions of the Health Care Reform Law:** Effective January 1, 2014, the risk spreading programs are applicable to certain of the Company's

commercial medical insurance products. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were only applicable for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the HCRL to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the HCRL.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans operating both inside and outside of the health insurance exchanges established under the HCRL. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company generally relies on providers, including certain network providers who are employees of Humana, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for the Company's risk scores under the program. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on an estimate of both its own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including the Company's historical experience in markets it has participated in over a long period of time, member demographics (including age and gender for its members and other health insurance issuers), its pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the HCRL. The Company refines its estimates as new information becomes available, including additional data released by HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there were no payments associated with these audits for 2015 or 2016, the pilot years for the audits. The Company risk adjustment data for 2018 and 2019 was selected for audit by HHS. The final assessment from this audit was immaterial to the statutory statements of revenues and expenses.

The temporary risk corridor program applied to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including the Company's small group health plans, were not subject to the risk corridor program. The risk corridor provisions were included to limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received

from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to the Company or require it to refund HHS a portion of the premiums the Company received.

The Company estimates and recognizes adjustments to earned premiums for the risk adjustment and risk corridor provisions by projecting its ultimate premium for the calendar year separately for individual and group plans by state. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. The Company records receivables or payables at the individual or group level within each state and classifies the amounts as current or long-term in the statutory statements of admitted assets, liabilities and surplus based on the timing of expected settlement.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the permanent HCRL risk adjustment and temporary risk corridor programs as of December 31, 2020 and 2019:

HCRL Risk Adjustment		
Assets	**2020**	**2019**
Premium adjustments receivable due to HCRL Risk Adjustment (including high risk pool payments)	$ 8,452,650	$ 9,396,756
Liabilities		
Risk adjustment user fees payable for HCRL Risk Adjustment	226,810	214,067
Premium adjustments payable due to HCRL Risk Adjustment (including high risk pool payments)	8,877,129	10,956,813
Operations (Revenue & Expenses)		
Reported as revenue in premium for accident and health contracts (written/collected) due to HCRL Risk Adjustment	12,371,151	11,761,211
Reported in expenses as HCRL risk adjustment user fees (incurred/paid)	99,711	119,266

HCRL Risk Corridor		
Assets	**2020**	**2019**
Accrued retrospective premium due to HCRL Risk Corridors	$ -	$ -
Liabilities		
Reserve for rate credits or policy experience rating refunds due to HCRL Risk Corridors	-	-
Operations (Revenue & Expenses)		
Effect of HCRL Risk Corridors on net premium income	51,059,517	-
Effect of HCRL Risk Corridors on change in reserves for rate credits	-	-

The risk corridor receivable activity by program year is presented below.

Risk Corridors Program Year	Estimated Amount to be Filed or Final Amount Filed with CMS	Non-Accrued Amounts for Impairment or Other Reasons	Amounts received from CMS	Assets Balance (Gross of Non-admissions)	Non-admitted Amount	Net Admitted Asset
2014	$ 18,112,622	$ -	$ 18,112,622	$ -	$ -	$ -
2015	17,262,854	-	17,262,854	-	-	-
2016	18,717,446	-	18,717,446	-	-	-
Total	$ 54,092,922	$ -	$ 54,092,922	$ -	$ -	$ -

On November 2, 2017, Humana filed suit against the United States of America in the United States Court of Federal Claims, on behalf of its health plans seeking recovery from the federal

government for payments under the risk corridor premium stabilization program established under the HCRL for years 2014, 2015 and 2016. On April 27, 2020, the U.S. Supreme Court ruled that the government is obligated to pay the losses under this risk corridor program, and that Congress did not impliedly repeal the obligation under its appropriations riders. In September 2020, the Company received $51,059,517 from the U.S. Government pursuant to the judgement issued by the Court of Federal Claims on July 7, 2020. The $51,059,517 payment received from the U.S. Government and $2,552,205 in related fees and expenses are reflected in net premium income and selling, general and administrative expenses, respectively.

A roll-forward of risk corridor assets, gross of any nonadmissions and liability balances by program year, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before Dec 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before Dec 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 -3)	Prior Year Accrued Less Payments (Col 2 -4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
Risk Corridors Program Year	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. 2014											
1. Accrued retrospective premium	-		15,079,217		(15,079,217)		15,079,217		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
b. 2015											
1. Accrued retrospective premium	-		17,262,854		(17,262,854)		17,262,854		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
c. 2016											
1. Accrued retrospective premium	-		18,717,446		(18,717,446)		18,717,446		A.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
d. Total for Risk Corridors	-	-	51,059,517	-	(51,059,517)	-	51,059,517	-		-	-

Explanations of adjustments

A. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

The transitional reinsurance program required the Company to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the HCRL in the individual commercial market were eligible for recoveries if individual claims exceed a specified threshold. Accordingly, the Company accounted for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in its statutory statements of revenue and expenses. The Company accounted for contributions made by individual commercial plans compliant with the HCRL, which were

subject to recoveries, as ceded premiums (a reduction of earned premiums) and similarly the Company accounted for any recoveries as ceded benefits (a reduction of benefits incurred and loss adjustment expenses) in its statutory statements of revenue and expenses.

The statutory statements of admitted assets, liabilities and surplus, and the statements of revenue and expenses include the following amounts associated with the transitional HCRL reinsurance program as of December 31, 2020 and 2019:

	2020	2019
Assets		
Amounts recoverable for claims paid due to HCRL Reinsurance	$ -	$ -
Amounts recoverable for claims unpaid due to HCRL Reinsurance (Contra Liability)	-	-
Amounts receivable relating to uninsured plans for contributions for HCRL Reinsurance	-	-
Liabilities		
Liabilities for contributions payable due to HCRL Reinsurance – not reported as ceded premium	-	-
Ceded reinsurance premiums payable due to HCRL Reinsurance	-	-
Liabilities for amounts held under uninsured plans contributions for HCRL Reinsurance	-	-
Operations (Revenues & Expenses)		
Ceded reinsurance premiums due to HCRL Reinsurance	-	-
Reinsurance recoveries (income statement) due to HCRL Reinsurance payments or expected payments	-	581,309
HCRL Reinsurance contributions – not reported as ceded premiums	-	-

Amounts recoverable for claims unpaid due to HCRL Reinsurance is a contra liability and is included in benefits and loss adjustment expenses payable on the statutory statements of admitted assets, liabilities and surplus.

A roll-forward of prior year HCRL risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balances are presented below:

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1-3)	Prior Year Accrued Less Payments (Col 2-4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1-3+7)	Cumulative Balance from Prior Years (Col 2-4+8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable (including high risk pool payments)	9,396,756		15,847,564		(6,450,808)		6,809,461		A.	358,653	
2. Premium adjustments (payables) (including high risk pool payments)		(10,956,813)		(4,599,391)		(6,357,422)		(1,170,650)	B.		(7,528,072)

3. Subtotal ACA Permanent Risk Adjustment Program	9,396,756	(10,956,813)	15,847,564	(4,599,391)	(6,450,808)	(6,357,422)	6,809,461	(1,170,650)		358,653	(7,528,072)
b. Transitional ACA Reinsurance Program											
1. Amounts recoverable for claims paid	-		-		-		-			-	
2. Amounts recoverable for claims unpaid (contra liability)	-		-		-		-			-	
3. Amounts receivable relating to uninsured plans	-		-		-		-			-	
4. Liabilities for contributions payable due to ACA Reinsurance-not reported as ceded premium		-		-		-		-			-
5. Ceded reinsurance premiums payable		-		-		-		-			-
6. Liability for amounts held under uninsured plans		-		-		-		-			-
7. Subtotal ACA Transitional Reinsurance Program	-	-	-	-	-	-	-	-		-	-
c. Temporary ACA Risk Corridors Program											
1. Accrued retrospective premium	-		51,059,517		(51,059,517)		51,059,517		C.	-	
2. Reserve for rate credits or policy experience rating refunds		-		-		-		-			-
3. Subtotal ACA Risk Corridors Program	-	-	51,059,517	-	(51,059,517)	-	51,059,517	-		-	-
d. Total for ACA Risk Sharing Provisions	9,396,756	(10,956,813)	66,907,081	(4,599,391)	(57,510,325)	(6,357,422)	57,868,978	(1,170,650)		358,653	(7,528,072)

Explanation for adjustments

A. Adjustments related to updates received from CMS associated with 2019 benefit year and the latest data from Wakely Consulting.

B. Small Group estimate changes for unfinalized years, based on latest data from Wakely Consulting.

C. Adjustment recorded for additional risk corridor payments received in 2020 that had been previously written off.

Net collections under the 3Rs associated with prior coverage years were $62,307,691 and $(10,957,828) in 2020 and 2019, respectively. The Company collected all reinsurance recoverables relating to prior coverage years in 2018.

m. Pharmacy Rebates: The Company benefits from several contractual agreements with pharmaceutical companies that offer rebates on certain prescription drugs based upon the rate of utilization through its agreement with Humana Pharmacy Solutions, Inc. (HPS) discussed in Note 9. The Company's method used to estimate rebates receivable is based on historical trends and actual amounts invoiced to manufacturers. These rebates are recorded as a reduction of benefits incurred and loss adjustment expenses in the accompanying statutory statements of revenue and expenses.

In accordance with SSAP No. 84, the following table summarizes the gross pharmacy rebate receivables included in admitted health care and other receivables in the accompanying statements of admitted assets, liabilities and surplus and the pharmacy rebates collected by quarter for 2020, 2019, and 2018:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More than 181 Days After Billing
12/31/2020	$ 865,801,825	$ 865,801,825	$ -	$ -	$ -
9/30/2020	1,168,556,064	1,168,556,064	1,160,387,128	-	-
6/30/2020	1,373,937,740	1,373,937,740	1,362,660,688	10,170,454	-
3/31/2020	1,082,989,376	1,082,989,376	1,058,456,911	24,387,760	-
12/31/2019	857,149,998	857,149,998	852,653,167	-	-
9/30/2019	983,974,614	983,974,614	976,954,193	2,515,299	4,505,122
6/30/2019	1,557,140,947	1,557,140,947	1,538,340,203	4,788,022	13,912,563
3/31/2019	1,105,668,614	1,105,668,614	1,095,342,361	-	10,326,253
12/31/2018	871,791,853	871,791,853	861,944,025	4,597,680	2,749,502
9/30/2018	1,019,941,316	1,019,941,316	1,016,254,784	3,686,532	-
6/30/2018	1,351,608,731	1,351,608,731	1,346,148,031	5,460,700	-
3/31/2018	914,970,239	914,970,239	914,970,239	-	-

Amounts not collected within 90 days of invoice or confirmation date are nonadmitted. Pharmacy rebates receivable of $16,517,875 and $28,534,552 were nonadmitted at December 31, 2020 and 2019, respectively.

n. Risk-Share Agreements: The Company negotiates contractual agreements with group Medicare customers, some of which contain gain sharing provisions in the event the benefit ratio is less than an agreed-upon level. In these agreements, the Company and the customers generally share evenly in the gain. The Company recorded gain share payable of $175,887,987 and $40,715,660 as of December 31, 2020 and 2019, respectively, which is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

o. Benefits Incurred and Loss Adjustment Expenses: Benefits incurred and loss adjustment expenses include claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health, dental and vision insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the

date of the statements of admitted assets, liabilities and surplus. Capitation payments represent monthly contractual fees disbursed to participating primary care physicians, and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Based on the nature of the expense, loss adjustment expenses are allocated between benefits incurred and loss adjustment expense and selling, general and administrative expense.

The estimates of future medical claim payments are estimated using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical development such as claim inventory levels and claim receipt patterns, and other relevant factors. Corresponding administrative costs to process outstanding claims are estimated and accrued. The Company continually reviews estimates of future payments relating to claims costs for services incurred in the current and prior periods and adjusts as necessary.

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

The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or forecasts indicate probable future losses. The Company establishes a premium deficiency reserve in the current year to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with how the Company's policies are marketed, serviced, and measured for the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established.

The Company recorded premium deficiency liabilities of $77,622,000 at December 31, 2020 but none were recorded at December 31, 2019. The liability at December 31, 2020 is included in aggregate health policy reserves in the accompanying statements of admitted assets, liabilities and surplus.

Management believes the Company's benefits and loss adjustment expenses payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

p. **Reserves for Life Contracts and Deposit-Type Contracts:** The Company waives the deduction of deferred fractional premiums upon death of the insured and holds net level or modified premium reserves on mortality and interest bases that are consistent with statutory guidance. The Company does not return any portion of the final premium for periods beyond the date of death. Surrender values are not promised in excess of the legally computed reserves.

As of December 31, 2020 and 2019 the Company did not have any life insurance in force for which the gross premiums were less than the net premiums according to the standard valuation set by the OCI, as described in SSAP No. 51, *Life Contracts* (SSAP No. 51). As discussed in Note 9, all non-health insurance business, including all associated reserves, was ceded to Humana Insurance Company of Kentucky (HICK) as of January 1, 2013.

q. **Administrative Service Only Contracts (ASO):** Administrative services fees cover the processing of claims, offering access to the Company's provider networks and clinical programs and responding to customer service inquiries from members of self-funded groups. Fees from providing administrative services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from Humana to cover catastrophic claims or to limit aggregate annual costs. The Company does not reflect payment of ASO claims in its statutory statements of revenue and expenses.

r. **Mortgage Loans:** Mortgage loans are current and carried at unpaid principal balances, net of discounts/premiums and valuation allowances. The Company has estimated the book/adjusted carrying value of its mortgage loans, to be $8,550,000 at December 31, 2020 and 2019. This estimate was established using a discounted cash flow method based on rating, maturity and future income when compared to the expected yield for mortgages having similar characteristics. The rating for mortgages in good standing is based on property type, location, market conditions, occupancy, debt service coverage, loan to value, caliber of tenancy, borrower and payment record. Problem mortgages are priced to reflect their monetary value to the Company, considering such things as the degree of default, whether or not the payments are still being made, interest rate, maturity and operating performance of the underlying collateral.

   During 2020 and 2019, the maximum and minimum lending rates for mortgage loans were 6.65% at both year ends. At the issuance of a loan, the percentage of loan to value on any one loan does not exceed 100.

s. **Nonadmitted Assets:** Nonadmitted assets, which typically consist of premiums receivable past due in excess of 90 days, deferred tax assets in excess of certain limits, electronic data processing software in excess of certain limits, furniture and equipment, prepaid commissions and expenses, deposits, pharmacy rebates and other receivables past due in excess of 90 days from the invoice date, are excluded from the statements of admitted assets, liabilities and surplus by direct charges to unassigned surplus in accordance with SSAP No. 4, *Assets and Nonadmitted Assets* (SSAP No. 4).

t. **Going Concern Considerations:** Management of the Company has evaluated the Company's ability to continue as a going concern under SSAP No. 1, *Accounting Policies, Risks & Uncertainties, and Other Disclosures* (SSAP No. 1). Based on this evaluation, Management has determined that there is no substantial doubt about the Company's ability to continue as a going concern.

u. **Reclassifications:** Certain prior year amounts have been reclassified to conform to the 2020 financial statement presentation. These reclassifications have no impact on the Company's reported surplus, net income, or net cash flows.

v. Subsequent Events: The Company evaluated subsequent events through April 29, 2021, the date these financial statements were issued or available to be issued.

On March 19, 2021, the Company requested to pay a dividend to its parent Humana of $750,000,000, of which, all was extraordinary. The Company received approval to pay the dividend from the OCI on March 29, 2021. On April 20, 2021, the Company paid the $750,000,000 dividend to Humana.

The Company is not aware of any other events or transactions occurring subsequent to the balance sheet date, but before the issuance of the financial statements which may have a material effect on its financial condition.

3. Bonds

The book/adjusted carrying value and estimated fair value of bonds at December 31, 2020 and 2019 were as follows:

	2020			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 86,450,865	$ 747,748	$ (91,962)	$ 87,106,651
States, territories and possessions	40,724,739	1,351,861	(129)	42,076,471
Political subdivisions of states, territories and possessions	60,193,948	2,047,422	-	62,241,370
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,426,364,809	65,255,683	(658,855)	1,490,961,637
Industrial and miscellaneous	2,493,333,034	130,020,825	(1,099,566)	2,622,254,293
Hybrid Securities	-	-	-	-
Total bonds	$ 4,107,067,395	$ 199,423,539	$ (1,850,512)	$ 4,304,640,422

	2019			
	Book/Adjusted Carrying Value	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U. S. Governments	$ 49,880,748	$ 146,367	$ (19,267)	$ 50,007,848
States, territories and possessions	82,100,971	1,337,974	(7,230)	83,431,715
Political subdivisions of states, territories and possessions	76,481,989	1,225,540	(8,034)	77,699,495
Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	1,471,704,396	32,996,082	(1,148,248)	1,503,552,230
Industrial and miscellaneous	1,896,705,219	40,483,442	(1,693,862)	1,935,494,799
Hybrid Securities	-	-	-	-
Total bonds	$ 3,576,873,323	$ 76,189,405	$ (2,876,641)	$ 3,650,186,087

The book/adjusted carrying value and estimated fair value of bonds and short-term investments at December 31, 2020, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties and because most structured securities provide for periodic payments through their lives.

	Book/Adjusted Carrying Value	Estimated Fair Value
Due in one year or less	$ 240,243,830	$ 240,781,223
Due after one year through five years	746,017,489	779,558,730
Due after five years through ten years	913,840,824	983,851,894
Due after ten years	576,415,408	602,108,463
Mortgage and asset-backed securities	1,797,939,483	1,865,725,755
	$ 4,274,457,034	$ 4,472,026,065

The detail of realized gains (losses) of bonds for the years ended December 31, 2020 and 2019 were as follows:

	2020	2019
Gross realized gains	$ 24,861,753	$ 17,011,113
Gross realized losses	(4,502,415)	(2,674,574)
Net realized gains	$ 20,359,338	$ 14,336,539

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

	2020					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ 47,281,417	$ (91,962)	$ -	$ -	$ 47,281,417	$ (91,962)
States, territories and possessions	7,304,848	(129)	-	-	7,304,848	(129)
Political subdivisions of states, territories and possessions	-	-	-	-	-	-
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	80,636,584	(658,855)	-	-	80,636,584	(658,855)
Industrial and misc.	222,903,328	(611,678)	114,016,835	(487,888)	336,920,163	(1,099,566)
Total invested assets	$ 358,126,177	$ (1,362,624)	$ 114,016,835	$ (487,888)	$ 472,143,012	$ (1,850,512)

	2019					
	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Governments	$ -	$ -	$ 11,573,060	$ (19,267)	$ 11,573,060	$ (19,267)
States, territories and possessions	-	-	13,613,712	(7,230)	13,613,712	(7,230)
Political subdivisions of states, territories and possessions	-	-	11,278,345	(8,034)	11,278,345	(8,034)
Special revenue and special assessment obligations and all non- guaranteed obligations of agencies and authorities of governments and their political subdivisions	156,178,517	(712,278)	64,880,895	(435,970)	221,059,412	(1,148,248)
Industrial and misc.	85,536,366	(336,295)	326,158,813	(1,357,567)	411,695,179	(1,693,862)
Total invested assets	$ 241,714,883	$ (1,048,573)	$ 427,504,825	$ (1,828,068)	$ 669,219,708	$ (2,876,641)

The unrealized loss from all debt securities was generated from 67 investment positions at December 31, 2020. All issuers of debt securities the Company owns that were trading at an unrealized loss at December 31, 2020 remain current on all contractual payments. After taking into account these and other factors previously described, the Company believes these unrealized losses primarily were caused by an increase in market interest rates in the current markets since the time the debt securities were purchased. At December 31, 2020, the Company did not intend to sell any debt securities with an unrealized loss position, and it is not likely that the Company will be required to sell these debt securities before recovery of their amortized cost basis. As a result, the Company believes that the debt securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2020.

Unrealized gains or losses on bonds deemed temporary are included as an adjustment to surplus in the statutory financial statements.

4. Reinsurance

The Company reinsures portions of its business through various reinsurance treaties. These treaties protect the Company from sustaining losses above predetermined levels and are included as a reduction of earned premiums in the accompanying statements of revenue and expenses. Although the reinsurer in each case is primarily liable on the insurance ceded, the Company remains liable to the insured whether or not the reinsurer meets its contractual obligations.

In 2020 and 2019, the Company did not commute any ceded reinsurance, nor did it enter into or engage in any agreement that reinsures policies or contracts that were in-force or had existing reserves as of the effective date of such agreements. No write-offs of reinsurance balances occurred in 2020 or 2019. The Company remains obligated for amounts ceded in the event that reinsurers do not meet their obligations.

The Company has a reinsurance contract with an affiliate as noted within Note 9. For the years ended December 31, 2020 and 2019 there were $48,245,098 and $50,534,711 premiums ceded, respectively, related to this contract.

The Company has not entered into any reinsurance agreements in which the reinsurer may unilaterally cancel any reinsurance for reasons other than nonpayment of premiums or other amounts due. The Company does not have any reinsurance agreements in effect in which the amount of losses paid or accrued through December 31, 2020 or 2019 would result in a payment to the reinsurer of amounts which, in the aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premiums collected under the reinsured policies. The Company does not have any reinsurance agreements subject to A-791 risk limiting provisions.

5. Income Taxes

The components of the net admitted deferred tax assets and deferred tax liabilities by character as of December 31, 2020 and 2019 were as follows:

	2020		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 154,254,430	$ 31,678	$ 154,286,108
Statutory valuation allowance adjustment	-	(31,678)	(31,678)
Adjusted gross deferred tax assets	154,254,430	-	154,254,430
Deferred tax assets nonadmitted	(18,129,081)	-	(18,129,081)
Subtotal net admitted deferred tax assets	136,125,349	-	136,125,349
Gross deferred tax liabilities	(5,551,401)	-	(5,551,401)
Net admitted deferred tax asset/(liability)	$ 130,573,948	$ -	$ 130,573,948

	2019		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 111,944,692	$ 214,010	$ 112,158,702
Statutory valuation allowance adjustment	-	(214,010)	(214,010)
Adjusted gross deferred tax assets	111,944,692	-	111,944,692
Deferred tax assets nonadmitted	(13,267,892)	-	(13,267,892)
Subtotal net admitted deferred tax assets	98,676,800	-	98,676,800
Gross deferred tax liabilities	(5,412,854)	-	(5,412,854)
Net admitted deferred tax asset/(liability)	$ 93,263,946	$ -	$ 93,263,946

None of the Company's ordinary (or capital) adjusted gross or net admitted DTAs were generated using tax planning strategies. There are no temporary differences for which a DTL has not been established.

The amount of admitted adjusted gross deferred tax assets under SSAP No. 101, *Income Taxes* (SSAP No. 101) as of December 31, 2020 and 2019 were as follows:

	December 31, 2020		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 126,823,217	$ -	$ 126,823,217
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	3,750,731	-	3,750,731
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	3,750,731
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	630,926,175
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	5,551,401	-	5,551,401
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 136,125,349	$ -	$ 136,125,349

	December 31, 2019		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 90,610,040	$ -	$ 90,610,040
Adjusted gross deferred tax assets expected to be realized after application of the threshold limitation	2,653,906	-	2,653,906
Adjusted gross deferred tax assets expected to be realized following the Balance Sheet date	XXX	XXX	2,653,906
Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	598,510,343
Adjusted gross deferred tax assets offset by gross deferred tax liabilities	5,412,854	-	5,412,854
Deferred tax assets admitted as the result of application of SSAP No. 101 total	$ 98,676,800	$ -	$ 98,676,800

The ratio percentage used to determine recovery period and threshold limitation amount was as follows:

	2020	2019
Ratio percentage used to determine recovery period and threshold limitation amount	390%	393%
Amount of adjusted capital and surplus used to determine recovery period and threshold limitation	$ 4,206,174,503	$ 3,990,068,953

The Company's tax planning strategies do not include the use of reinsurance.

The significant components of federal income taxes incurred for the years ended December 31, 2020 and 2019 consisted of the following:

	2020	2019
Current year income tax provision	$ 404,289,613	$ 283,808,079
Revisions in prior years' estimated taxes	(5,413,981)	(3,785,230)
Federal income tax expense excluding the tax on realized capital gains and before change in net deferred income taxes	398,875,632	280,022,849
Tax on realized capital gains	19,620,490	3,010,673
Change in net deferred income taxes	(42,171,191)	(21,574,734)
Total statutory income taxes	$ 376,324,931	$ 261,458,788

The tax effects of temporary differences that give rise to significant portions of the DTAs and DTLs in the Company's statements of admitted assets, liabilities and surplus at December 31, 2020 and 2019 were as follows:

	2020	2019	Change
DTAs resulting from book/tax differences in			
Ordinary			
Discounting of unpaid losses	$ 51,347,974	$ 32,199,087	$ 19,148,887
Advance premiums	6,407,783	4,122,960	2,284,823
Policyholder reserves	234,972	186,900	48,072
Investments	-	-	-
Deferred acquisition costs	30,714,469	24,683,173	6,031,296
Policyholder dividends accrual	-	-	-
Fixed assets	-	-	-
Compensation and benefit accruals	22,884,214	21,648,132	1,236,082
Pension accruals	-	-	-
Receivables - nonadmitted	-	-	-
Net operating loss carryforwards	-	-	-
Tax credit carryforward	-	-	-
Other	3,060,058	2,092,226	967,832
Bad debts	-	2,582,190	(2,582,190)
Accrued litigation	1,646,820	1,562,913	83,907
CMS Rx reserves	23,812,375	20,303,218	3,509,157
CMS risk corridor – ACA	-	-	-
Medicare risk adjustment data	-	-	-
Miscellaneous reserves	1,459,228	732,177	727,051
Accrued lease	2,120,779	502,952	1,617,827
Section 197 intangibles	266,567	300,963	(34,396)
Premium rebates MER	8,603,109	-	8,603,109
Provider contracts	1,696,082	1,027,801	668,281
Premium acquisition expense	-	-	-
Gross ordinary DTAs	154,254,430	111,944,692	42,309,738
Statutory valuation allowance adjustment	-	-	-
Nonadmitted ordinary DTAs	(18,129,081)	(13,267,892)	(4,861,189)
Admitted ordinary DTAs	136,125,349	98,676,800	37,448,549
Capital			
Investments	31,678	214,010	(182,332)
Net capital loss carryforwards	-	-	-
Real estate	-	-	-
Other	-	-	-
Gross capital DTAs	31,678	214,010	(182,332)
Statutory valuation allowance adjustment	(31,678)	(214,010)	182,332
Nonadmitted capital DTAs	-	-	-
Admitted capital DTAs	-	-	-
Admitted DTAs	$ 136,125,349	$ 98,676,800	$ 37,448,549

	2020	2019	Change
DTLs resulting from book/tax differences in			
Ordinary			
Investments	$ -	$ -	$ -
Fixed assets	(3,160,279)	(3,042,623)	(117,656)
Deferred and uncollected premium	-	-	-
Policyholder reserves	-	-	-
Other	-	-	-
Premium acquisition expense	(72,486)	(78,410)	5,924
Bad debts	(408,785)	-	(408,785)
Reserve transition adjustment	(1,909,851)	(2,291,821)	381,970
Ordinary DTLs	(5,551,401)	(5,412,854)	(138,547)
Capital			
Investments	-	-	-
Real estate	-	-	-
Other	-	-	-
Capital DTLs	-	-	-
DTLs	(5,551,401)	(5,412,854)	(138,547)
Net deferred tax assets/(liabilities)	$ 130,573,948	$ 93,263,946	$ 37,310,002

The Company considers all available sources of income in determination of the need for a statutory valuation allowance. There is no statutory valuation allowance on the ordinary portion of the DTA as the tax allocation agreement between the Company and Humana grants the Company the enforceable right to be paid for future losses it may incur. There is no ordinary DTA generated by the Company which Humana does not expect the consolidated tax filing group to benefit from. A statutory valuation allowance has been set up for deferred taxes on future capital loss items, due to uncertainty regarding the timing of their reversal.

The change in nonadmitted deferred tax assets from December 31, 2019 to 2020 was an increase of $4,861,189. The change in nonadmitted deferred tax assets from December 31, 2018 to 2019 was an increase of $2,943,725.

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes due principally to the HCRL fee, dividends received deduction and nonadmitted assets and deferred tax true-ups in 2020.

The Company had no net operating loss carryforwards at December 31, 2020 or 2019.

The following table demonstrates the income tax expense for 2019 and 2020 that is available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2019	$ 278,394,098	$ 3,010,673	$ 281,404,771
2020	404,289,613	19,620,490	423,910,103
	$ 682,683,711	$ 22,631,163	$ 705,314,874

There are no deposits admitted under IRC § 6603, *Deposits Made to Suspend Running of Interest on Potential Underpayments*.

The Company is included in the consolidated federal income tax return of Humana and its wholly owned subsidiaries. Under a written agreement, Humana allocates its federal income tax liability among the subsidiaries of the consolidated return group (including the Company) based on the ratio that each subsidiary's separate return tax liability for the year bears to the sum of the separate return liabilities of all subsidiaries. Benefits for net operating losses are recognized currently. The final settlement under this agreement is made after the annual filing of the consolidated income tax return.

As part of the consolidated income tax return of Humana, the Company has accrued no tax contingencies during 2020 or 2019.

As of December 31, 2020, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase or decrease within 12 months of the reporting date. Humana files income tax returns in U.S. federal jurisdiction and several state jurisdictions. The U.S. Internal Revenue Service (IRS) has completed its examinations of Humana's consolidated income tax returns for 2017 and prior years. Humana's 2018 and 2019 tax returns are in the post-filing review period under the Compliance Assurance Process (CAP). Humana's 2020 tax return is under advance review by the IRS under CAP. Humana is not aware of any material adjustments that may be proposed as a result of any ongoing or future examinations.

The names of the entities with whom the Company's federal income tax return is consolidated for the current year include the following:

HUMANA INC. AND SUBSIDIARIES INCLUDED IN 2020 CONSOLIDATED FEDERAL INCOME TAX RETURN

CALENDAR YEAR ENDED DECEMBER 31, 2020
AFFILIATIONS SCHEDULE

CORPORATE NAME AND EMPLOYER IDENTIFICATION NUMBER
THE ADDRESS OF EACH COMPANY IS: P. O. BOX 740026, LOUISVILLE, KY 40201

CORP. NO.	CORPORATION NAME	EMPLOYER IDENTIFICATION NUMBER
1	HUMANA INC.	61-0647538
2	154TH STREET MEDICAL PLAZA, INC.	65-0851053
3	516-526 WEST MAIN STREET CONDOMINIUM COUNCIL OF CO-OWNERS, INC.	20-5309363
4	54TH STREET MEDICAL PLAZA, INC.	65-0293220
5	ARCADIAN HEALTH PLAN, INC.	20-1001348
6	CAC MEDICAL CENTER HOLDINGS, INC.	30-0117876
7	CAC-FLORIDA MEDICAL CENTERS, LLC	26-0010657
8	CARENETWORK, INC.	39-1514846
9	CAREPLUS HEALTH PLANS, INC.	59-2598550
10	CARITEN HEALTH PLAN INC.	62-1579044
11	CHA HMO, INC.	61-1279717
12	COMPBENEFITS COMPANY	59-2531815
13	COMPBENEFITS CORPORATION	04-3185995
14	COMPBENEFITS DENTAL, INC.	36-3686002

15	COMPBENEFITS DIRECT, INC.	58-2228851
16	COMPBENEFITS INSURANCE COMPANY	74-2552026
17	COMPLEX CLINICAL MANAGEMENT, INC.	45-3713941
18	CONTINUCARE CORPORATION	59-2716023
19	CONTINUCARE MEDICAL MANAGEMENT, INC.	65-0791417
20	CONVIVA HEALTH MANAGEMENT, LLC (f/k/a TRANSCEND POPULATION HEALTH MANAGEMENT, LLC)	46-5329373
21	CONVIVA HEALTH MSO OF TEXAS, INC. (f/k/a PRIMARY CARE HOLDINGS, INC.)	46-1225873
22	CONVIVA MEDICAL CENTER MANAGEMENT OF TEXAS, P.A. (f/k/a PARTNERS IN PRIMARY CARE, P.A.)	47-1161014
23	DENTAL CARE PLUS MANAGEMENT, CORP.	36-3512545
24	DENTICARE, INC.	76-0039628
25	EAGLE RX HOLDCO, INC.	47-1407967
26	EAGLE RX, INC.	47-1416614
27	EDGE HEALTH MSO, INC.	84-2214810
28	EDGE HEALTH, P.C.	84-2752906
29	EMPHESYS INSURANCE COMPANY	31-0935772
30	EMPHESYS, INC.	61-1237697
31	ENCLARA PHARMACIA, INC.	23-3068914
32	FAMILY PHYSICIANS OF WINTER PARK, INC.	59-3164234
33	FPG ACQUISITION CORP.	81-3802918
34	FPG ACQUISITION HOLDINGS CORP.	81-3819187
35	FPG HOLDING COMPANY, LLC	32-0505460
36	GUIDANTRX, INC.	39-1789830
37	HARRIS, ROTHENBERG INTERNATIONAL, INC.	27-1649291
38	HEALTH VALUE MANAGEMENT, INC.	61-1223418
39	HUMANA ACTIVE OUTLOOK, INC.	20-4835394
40	HUMANA AT HOME (DALLAS), INC.	75-2739333
41	HUMANA AT HOME (HOUSTON), INC.	76-0537878
42	HUMANA AT HOME (SAN ANTONIO), INC.	01-0766084
43	HUMANA AT HOME (TLC), INC.	75-2600512
44	HUMANA AT HOME 1, INC.	65-0274594
45	HUMANA AT HOME, INC.	13-4036798
46	HUMANA BENEFIT PLAN OF ILLINOIS, INC.	37-1326199
47	HUMANA BENEFIT PLAN OF SOUTH CAROLINA, INC.	84-3226630
48	HUMANA BENEFIT PLAN OF TEXAS, INC.	75-2043865
49	HUMANA DENTAL COMPANY	59-1843760
50	HUMANA DIGITAL HEALTH AND ANALYTICS PLATFORM SERVICES, INC.	80-0072760
51	HUMANA DIRECT CONTRACTING ENTITY, INC.	85-3099097
52	HUMANA EAP AND WORK-LIFE SERVICES OF CALIFORNIA, INC.	46-4912173
53	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.	58-2209549
54	HUMANA GOVERNMENT BUSINESS, INC.	61-1241225
55	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC.	72-1279235
56	HUMANA HEALTH COMPANY OF NEW YORK, INC.	26-2800286
57	HUMANA HEALTH INSURANCE COMPANY OF FLORIDA, INC.	61-1041514
58	HUMANA HEALTH PLAN OF CALIFORNIA, INC.	26-3473328
59	HUMANA HEALTH PLAN OF OHIO, INC.	31-1154200
60	HUMANA HEALTH PLAN OF TEXAS, INC.	61-0994632

61	HUMANA HEALTH PLAN, INC.	61-1013183
62	HUMANA HEALTHCARE RESEARCH, INC.	42-1575099
63	HUMANA HOME ADVANTAGE (TX), P.A.	81-0789608
64	HUMANA INNOVATION ENTERPRISES, INC.	61-1343791
65	HUMANA INSURANCE COMPANY	39-1263473
66	HUMANA INSURANCE COMPANY OF KENTUCKY	61-1311685
67	HUMANA INSURANCE COMPANY OF NEW YORK	20-2888723
68	HUMANA MARKETPOINT, INC.	61-1343508
69	HUMANA MEDICAL PLAN OF MICHIGAN, INC.	27-3991410
70	HUMANA MEDICAL PLAN OF PENNSYLVANIA, INC.	27-4460531
71	HUMANA MEDICAL PLAN OF UTAH, INC.	20-8411422
72	HUMANA MEDICAL PLAN, INC.	61-1103898
73	HUMANA PHARMACY SOLUTIONS, INC.	45-2254346
74	HUMANA PHARMACY, INC.	61-1316926
75	HUMANA REAL ESTATE COMPANY	20-1724127
76	HUMANA REGIONAL HEALTH PLAN, INC.	20-2036444
77	HUMANA VETERANS HEALTHCARE SERVICES, INC.	20-8418853
78	HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION	39-1525003
79	HUMANADENTAL INSURANCE COMPANY	39-0714280
80	HUMANADENTAL, INC.	61-1364005
81	HUMCO, INC.	61-1239538
82	HUM-e-FL, INC.	61-1383567
83	MANAGED CARE INDEMNITY, INC.	61-1232669
84	MEDICAL CARE CONSORTIUM INCORPORATED OF TEXAS	27-4379634
85	METCARE OF FLORIDA, INC.	65-0879131
86	METROPOLITAN HEALTH NETWORKS, INC.	65-0635748
87	PARTNERS IN INTEGRATED CARE, INC.	47-2905609
88	PARTNERS IN PRIMARY CARE (GA), P.C.	83-2624178
89	PARTNERS IN PRIMARY CARE (KS), P.A.	30-1236218
90	PARTNERS IN PRIMARY CARE (KS), P.C.	85-0733589
91	PARTNERS IN PRIMARY CARE (MO), P.C.	85-3676937
92	PARTNERS IN PRIMARY CARE (NC), P.C.	82-1926920
93	PARTNERS IN PRIMARY CARE (SC), P.C.	85-3577914
94	PBM HOLDING COMPANY	61-1340806
95	PBM PLUS MAIL SERVICE PHARMACY, LLC	20-2373204
96	PHP COMPANIES, INC.	62-1552091
97	PREFERRED HEALTH PARTNERSHIP, INC.	62-1250945
98	PRIMARY CARE MANAGEMENT, INC.	85-0858631
99	ROHC, LLC	75-2844854
100	SENIORBRIDGE FAMILY COMPANIES (FL), INC.	65-1096853
101	SENIORBRIDGE FAMILY COMPANIES (NY), INC.	36-4484443
102	TEXAS DENTAL PLANS, INC.	74-2352809
103	THE DENTAL CONCERN, INC.	52-1157181
104	TRANSCEND COMMUNITY PHYSICIAN NETWORK (AR), P.A.	47-2770181
105	TRANSCEND COMMUNITY PHYSICIAN NETWORK (KS), P.A.	47-2111323
106	TRANSCEND COMMUNITY PHYSICIAN NETWORK, P.C.	47-2750105

6. Benefits and Loss Adjustment Expenses Payable

Activity in benefits and loss adjustment expenses payable for the years ended December 31, 2020 and 2019 are summarized as follows:

	2020	2019
Balance at January 1,	$ 2,440,353,699	$ 2,202,442,434
Health care receivables	(875,408,931)	(885,945,143)
Balance at January 1, net of health care receivables	1,564,944,768	1,316,497,291
Benefits incurred and loss adjustment expenses related to		
Current year	24,484,225,543	22,968,450,349
Prior year	(103,937,418)	(33,239,174)
	24,380,288,125	22,935,211,175
Benefits and loss adjustment expenses paid related to		
Current year	22,105,141,890	21,417,748,471
Prior year	1,445,302,987	1,269,015,227
	23,550,444,877	22,686,763,698
Balance at December 31,	3,291,927,287	2,440,353,699
Health care receivables	(897,139,271)	(875,408,931)
Balance at December 31, net of health care receivables	$ 2,394,788,016	$ 1,564,944,768

Benefits and loss adjustment expenses payable, net of healthcare receivables, as of December 31, 2019 were $1,564,944,768. As of December 31, 2020, $1,445,302,987 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $15,704,363 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $103,937,418 favorable prior-year development since December 31, 2019. The decrease is generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included in this decrease, the Company experienced $80,469,233 of favorable prior year claim development on retrospectively rated policies. However, the business to which it relates is subject to premium adjustments.

7. Dividend Restrictions

Dividends or returns of capital to shareholders are noncumulative and are paid as determined by the Board of Directors. In accordance with the OCI statutes, the maximum amount of dividends or returns of capital to shareholders which can be paid by the Company without prior approval by the OCI is the lesser of 10% of total surplus or net gain from operations from the prior year. All ordinary dividends are limited to available and accumulated surplus funds. Based on these restrictions, the Company could have paid a maximum dividend or return of capital to shareholders of approximately $412,900,000 in 2020 without prior regulatory approval.

Dividends or returns of capital to shareholders paid by the Company are listed below. These dividends or returns of capital to shareholders are included as dividends or returns of capital paid from unassigned surplus in the accompanying statements of changes in surplus depending on the Company's position each year, in accordance with state regulations. Extraordinary amounts have been approved by the OCI.

		Dividend or Return of Capital Amount		
		Ordinary	Extraordinary	Date Paid
Dividend		$ 300,000,000	$ -	April 7, 2020
Dividend		-	650,000,000	December 21, 2020
	Total paid in 2020	$ 300,000,000	$ 650,000,000	
Dividend		$ -	$ 575,000,000	April 30, 2019
Dividend		-	100,000,000	December 19, 2018
	Total paid in 2019	$ -	$ 675,000,000	

8. Risk Based Capital Requirements

The Company is required to report an assessment of its solvency based upon the NAIC's Managed Care Organizations RBC analysis formulas. This RBC requirement, referred to as ACL, is the minimum level of capital deemed necessary for a health insurer based on the assets held and business written. The state of Wisconsin has passed legislation to adopt RBC. The Company's Total Adjusted Capital must be equal to or above its ACL RBC of $1,079,681,341 or the Company, under the discretion of the Commissioner of the OCI, could be placed under regulatory control.

In addition, the Company must comply with the regulations of the state of Wisconsin which require a minimum capital and surplus level of $3,879,748,974 or the Company could be subject to regulatory action. The Company maintained capital and surplus of $4,375,363,823 and $4,129,404,995 as of December 31, 2020 and 2019, respectively.

9. Related Party Transactions

The Company has a written management agreement with Humana and other related parties whereby the Company is provided with medical and executive management, information systems, claims processing, billing and enrollment, and telemarketing and other services as required by the Company. These fees are allocated to benefits incurred and loss adjustment expenses and selling, general and administrative expenses based on the nature of the services performed. Management fee expenses related to services which are shared with other related parties are allocated to the Company using a method that approximates an amount as if the expense had been incurred solely by the Company.

As a part of this agreement, Humana makes cash disbursements on behalf of the Company which include, but are not limited to, general and administrative expenses and payroll.

A wholly owned insurance subsidiary of Humana insures certain professional liability risks for the Company. Included in selling, general and administrative expenses are charges for such coverage of $2,099,339 and $3,158,543 for the years ended December 31, 2020 and 2019, respectively.

Employees of the Company participate in stock based compensation plans that are sponsored by Humana for which the Company has no legal obligation. The costs associated with these plans are being allocated to the Company based on detailed cost examination and interview processes. As of December 31, 2020 and 2019 total allocated expenses associated with these plans were $32,774,049 and $25,328,381, respectively, and are included in the management fee noted below.

Transactions under management agreements and service contracts charged to operations for the years ended December 31, 2020 and 2019 were $(666,086,637) and $(497,630,601), respectively, which are recorded as a charge to benefits incurred and loss adjustment expenses and selling, general and administrative expenses in the accompanying statutory statements of revenue and expenses. These amounts are net of fees received for services provided to wholly owned

subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates. These transactions include the expense incurred under the inter-company tax sharing agreement, discussed in Note 5, which were $433,700,804 and $298,325,325 for the years ended December 31, 2020 and 2019, respectively. These amounts are net of fees received for services provided to wholly owned subsidiaries of Humana whereby the Company provides claims processing, billing and enrollment and other services as required by the subsidiaries. These amounts are allocated to the affiliates using a method that approximates an amount as if the expense had been incurred solely by the affiliates. The Company continues to be primarily liable for any outstanding payments made on behalf of the Company should Humana not be able to fulfill its obligations.

The Company reported $183,694,631 and $192,687,773 due from Humana at December 31, 2020 and 2019, respectively, all of which was settled between the Company and Humana subsequent to both year ends.

In the ordinary course of business, the Company also directly contracts with related parties to provide services that are routine in nature to its members. The administrative services, access fees, and cost of care services provided are determined within each individual agreement. These amounts are included in benefits incurred and loss adjustment expenses as well as selling, general and administrative expenses in the statutory statements of revenue and expenses.

The following table identifies the amount for the administrative services, access fees, and cost of care services provided by related parties for the years ended December 31, 2020 and 2019, which meet the disclosure requirements pursuant to SSAP No. 25, *Affiliate and Other Related Parties* (SSAP No. 25):

		2020	2019
SeniorBridge and Humana At Home	$	132,608,792	$ 164,357,710
Total	$	132,608,792	$ 164,357,710

In addition to the related parties above, the Company also has a contracted relationship with Humana Pharmacy Solutions, Inc. (HPS). HPS is responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims for Humana entities. HPS has various contracts with pharmacy manufacturers to provide the Company with purchase discounts and volume rebates on certain prescription drugs utilized by its members. The Company has an agreement with HPS to collect pharmacy rebates on its behalf and remit them to the Company on a monthly basis. Any pharmacy rebates not yet received by but due from the pharmacy manufacturers are included in health care and other receivables in the statements of admitted assets, liabilities and surplus. See Note 2(m) for further consideration of related pharmacy rebates. The Company had $16,940,564,801 and $16,437,891,312 of administrative service and prescription costs in 2020 and 2019, respectively, with HPS. The prescription costs included in fees paid to HPS are gross of the pharmacy rebates that the Company receives and also includes payments for Medicare Part D claims that CMS reimburses the Company for through the Coverage Gap, Low Income and Reinsurance subsidies, discussed in Note 2(k).

Included in the payments to HPS are also costs incurred from Humana Pharmacy, Inc. Humana Pharmacy, Inc. provides covered members with prescription services through use of the mail order as well as brick and mortar locations. These services are limited to maintenance medication prescription drug and allied services and supplies normally provided to the general public in the ordinary course of pharmacy business. The Company had $3,828,375,734 and $3,745,299,190 of prescription costs in 2020 and 2019, respectively, with Humana Pharmacy, Inc.

The Company has an intercompany reinsurance agreement with its subsidiary HICK. Under the terms of the contract, the Company cedes business including all of it group life, specified disease, disability income, and accident insurance business. For the years ended December 31, 2020 and 2019 there were $48,245,098 and $50,534,711 premiums ceded, respectively, related to this agreement.

The Company entered into a mortgage agreement with Humana on property held by the Company effective February 1, 1999, for $8,550,000 plus accrued interest. The note bears interest only at the rate of 6.65%. The principal and accrued interest amounts were originally due and payable to the Company on January 31, 2009, however, the due date was extended to January 31, 2022. The Company carries this note at book value of $8,550,000.

The Company received no capital contributions in the years ended December 31, 2020 or 2019.

Humana forgave $19,984,786 of the Company's tax liability due to Humana as part of the Company's tax sharing agreement during 2019. The portion of the tax balance being forgiven is associated with an issue that was previously subject to IRS Appeals. The forgiveness was accounted for as contributed surplus per SSAP No. 72 *Surplus and Quasi-Reorganizations* (SSAP No. 72).

10. Employee Benefit Plans

The Company's employees are eligible to participate in the Humana Retirement Savings Plan (the Plan), a defined contribution plan, sponsored by Humana. The Plan maintains two accounts, the Savings Account and the Retirement Account. Humana's total contributions paid to the Plan were $233,856,665 and $219,268,247 for the years ended December 31, 2020 and 2019, respectively. Of these contributions, the Company contributed $123,082,595 and $110,527,415 during 2020 and 2019, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses. As of December 31, 2020 and 2019, the fair market value of the Humana Retirement Savings Plan's assets were $6,280,051,531 and $5,344,599,370, respectively.

11. Lease Commitments

The Company has entered into operating leases for medical and administrative office space and equipment with lease terms ranging from one to six years. Operating lease rental payments charged to expenses for the years ended December 31, 2020 and 2019 were $21,685,077 and $40,170,122, respectively, which are included in selling, general and administrative expenses in the accompanying statements of revenue and expenses.

In 2020 and 2019 the Company terminated lease agreements early resulting in the recognition of a liability included within accounts payable and accrued expenses within the accompanying statements of admitted assets, liabilities and surplus. The following table includes the leases terminated and the related liability remaining at December 31, 2020 and 2019:

	2020	2019
Tempe Commerce Center	$ 170,098	$ 359,844
Irvine CA KMG Office	48,522	-
Total liability	$ 218,620	$ 359,844

Future minimum rental payments required under operating leases as of December 31, 2020, which have initial or remaining noncancelable lease terms in excess of one year, were as follows:

Years Ended December 31,		
2021	$	22,105,613
2022		18,807,609
2023		10,401,301
2024		5,700,696
2025		4,998,834
Thereafter		12,714,834
Total minimum lease payments	$	74,728,887

12. Contingencies and Concentrations of Risk

a. CMS Contracts: The Company's MA and Medicare Part D contracts (the Contracts) with CMS are renewed generally for a calendar year term unless CMS notifies the Company of its decision not to renew by May 1 of the calendar year in which the contract would end, or the Company notifies CMS of its decision not to renew by the first Monday in June of the calendar year in which the contract would end. Earned premiums relating to the Contracts were $26,181,957,434 and $23,670,125,040 for the years ended December 31, 2020 and 2019, respectively. The loss of the Contracts (which are generally renewed annually) or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments, or increases in member benefits or changes to member eligibility criteria without corresponding increases in premium payments, may have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows. All material contracts between the Company and CMS relating to its Medicare products have been renewed for 2021, and all product offerings filed with CMS for 2021 have been approved.

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

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

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

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

The final RADV extrapolation methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to CMS RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for certain of the Company's Medicare Advantage plans for payment years 2015 and 2014. CMS completed its RADV contract level audit of the 2012 payment year, but has not yet provided the results.

Estimated audit settlements are recorded as a reduction of earned premiums in the statutory statements of revenue and expenses, based upon available information. The Company performs internal contract level audits based on the RADV audit methodology prescribed by CMS. To date, the Company has completed these audits for payment years 2011-2016. Included in these internal contract level audits is an audit of the Company's Private Fee-For-Service business which the Company used to represent a proxy of the FFS Adjuster which has not yet been finalized. The Company based its accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update its estimates as each audit is completed. Estimates derived from these results were not material to the Company's statutory

statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus, and cash flows. The Company reports the results of these internal contract level audits to CMS, including identified overpayments, if any.

On October 26, 2018, CMS issued a proposed rule and accompanying materials (which are referred to as the "Proposed Rule") related to, among other things, the RADV audit methodology described above. If implemented, the Proposed Rule would use extrapolation in RADV audits applicable to payment year 2011 contract-level audits and all subsequent audits, without the application of a FFS Adjuster to audit findings. Humana believes that the Proposed Rule fails to address adequately the statutory requirement of actuarial equivalence, and has provided substantive comments to CMS on the Proposed Rule as part of the notice-and-comment rulemaking process. Whether, and to what extent, CMS finalizes the Proposed Rule, and any related regulatory, industry or company reactions, could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

In addition, as part of the Company's internal compliance efforts, it routinely performs ordinary course reviews of its internal business processes related to, among other things, its risk coding and data submissions in connection with the risk-adjustment model. These reviews may also result in the identification of errors and the submission of corrections to CMS, that may, either individually or in the aggregate, be material. As such, the results of these reviews may have a material adverse effect on the Company results of statutory statements of revenue and expenses, changes in surplus or cash flows.

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

The Company will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on the Company's statutory statements of admitted assets, liabilities and surplus, and related statutory statements of revenue and expenses, changes in surplus and cash flows.

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

b. **COVID-19:** The emergence and spread of the novel coronavirus, or COVID-19, has impacted the Company's business. Beginning in the second half of March 2020, the implementation of stay-at-home and physical distancing orders and other restrictions on movement and economic activity resulted in the temporary deferral of non-essential care and significant reduction in hospital admissions and overall healthcare system utilization during April 2020. Non-COVID utilization then began to increase during May and June 2020 and continued to rebound throughout the third quarter and early in the fourth quarter of 2020. Then, in the latter half of November and accelerating throughout the month of December, the Company experienced a significant increase in COVID-19 admissions in nearly all of the markets in which it operates across the Company's lines of business resulting in higher COVID-19 treatment and testing costs. During this period, the Company also experienced a corresponding decline in non-COVID utilization in all service categories. The impact of this decline in non-COVID utilization more than offset the higher COVID-19 treatment and testing costs during the period. The Company's 2020 results were also impacted by ongoing pandemic relief efforts.

c. **Legal Proceedings:** During the ordinary course of business, the Company is subject to pending and threatened legal actions. Management of the Company does not believe any of these actions will have a material adverse effect on the Company's statements of admitted assets, liabilities and surplus, or on the related statutory statements of revenue and expenses, changes in surplus and cash flows. The outcome of current or future litigation or governmental or internal investigations cannot be accurately predicted nor can the Company predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on statutory statements of revenue and expenses, changes in surplus and cash flows, and may also affect the Company's reputation.

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

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

discovery with the relator who has pursued the matter on behalf of the United States following its unsealing, and expects the Court to consider its motion for summary judgment.

d. Economic Risks: General inflationary pressures may affect the costs of medical and other care, increasing the costs of claims expenses submitted to the Company.

e. Securities & Credit Markets Risks: Ongoing volatility or disruption in the securities and credit markets could impact the Company's investment portfolio. The Company evaluates investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. There is a continuing risk that declines in fair value may occur and material realized losses from sales or credit related impairments may be recorded in future periods.

f. Penn Treaty: Penn Treaty is a financially distressed unaffiliated long-term care insurance company. On March 1, 2017, the Pennsylvania Commonwealth Court approved the liquidation of Penn Treaty. Under state guaranty assessment laws, including those related to state cooperative failures in the industry, the Company may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as the Company. This court ruling triggered a guaranty fund assessment for the Company in the first quarter of 2017. Based on current information, the assessment is estimated at approximately $26,032,041 with a remaining unpaid balance as of December 31, 2020 of $8,132,296 included in accounts payable and accrued expenses in the accompanying statements of admitted assets, liabilities and surplus. The Company has also recognized an asset for premium tax credits associated with the assessment at December 31, 2020 and 2019 of $10,174,786 and $12,463,679, respectively, which are expected to be realized over the next 20 years. While the ultimate payment timing and associated recovery is currently unknown, the Company anticipates that the majority of the assessments will be paid within the next 5 years.

The below table reconciles the asset for premium tax credits associated with the assessment at December 31, 2019 to those reported at December 31, 2020.

a.) Assets recognized from paid and accrued premium tax offsets and policy surcharges prior year-end	$	12,463,679
b.) Decreases current year:		
Credits Used		2,203,030
Misc. Adjustments		85,863
c.) Increases current year:		-
d.) Assets recognized from paid and accrued premium tax offsets and policy surcharges current year-end	$	10,174,786

Discount rate applied: 3.50%

The Undiscounted and Discounted Amount of the Guaranty Fund assessments and Related Assets by Insolvency:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty	$ 36,965,498	$ 26,032,041	$ 28,063,537	$ 10,174,786

Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency:

	Payables			Recoverables		
Name of the Insolvency	Number of Jurisdictions	Range of Years	Weighted Average Number of Years	Number of Jurisdictions	Range of Years	Weighted Average Number of Years
Penn Treaty	50 states	1 to 70 years	11.96 years	39 states	1 to 20 years	8.1 years

13. Uninsured Plans

Information for the year ended December 31, 2020 regarding the profitability of ASO plans and the uninsured portion of partially insured plans for which the Company provides administrative services were as follows:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	$ (1,827,815)	$ (7,967,010)	$ (9,794,825)
Total net other income or expenses (including interest paid to or received from plans)	(1,342)	(5,848)	(7,190)
Net gain or (loss) from operations	$ (1,829,157)	$ (7,972,858)	$ (9,802,015)
Total claim payment volume	103,403,274	450,710,146	554,113,420

As of December 31, 2020, the Company has recorded a receivable from CMS of $1,119,108,271 related to the cost share and reinsurance components of administered Medicare products and a receivable from ASO customers of $10,178,350. The Company has recorded receivables from the following payors whose account balance are greater than 10% of the Company's accounts receivable from uninsured accident and health plans or $10,000:

	2020
Maricopa Community College	$ 1,103,885
Excela Health	623,523

	2019
Advocate Health Care APP	$ 2,653,200
Excela Health	1,125,444
Maricopa Community College	1,116,047
Baptist Health Floyd	921,229

Supplemental Investment Information

Humana Insurance Company
Investment Risk Interrogatories
Statutory Basis of Accounting
December 31, 2020

Of the **Humana Insurance Company**
Insurance Company Address (City, State, Zip Code) P.O. Box 740036 Louisville, Kentucky 40201-7436

NAIC Group Code 0119 NAIC Company Code 73288 Employer's ID Number 39-1263473
The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by stating the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 3 of the statement of admitted assets, liabilities and surplus. $9,393,515,033.

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	Federal National Mortgage Association	MBS	$ 631,040,752	6.72%
2.02	Freddie Mac	MBS CMO Bonds	320,988,597	3.42%
2.03	Apple Inc.	Commercial Paper	104,986,428	1.12%
2.04	Federal Home Loan Banks	Bonds	95,996,944	1.02%
2.05	Citigroup Inc.	Bonds	51,735,812	0.55%
2.06	Bank of America Corporation	Bonds	49,957,539	0.53%
2.07	Wells Fargo & Company	Bonds	46,867,597	0.50%
2.08	Cd 2017-Cd3	MBS	46,654,855	0.50%
2.09	Dormitory Authority of the State of New York	MBS	45,179,560	0.48%
2.10	Morgan Stanley	Bonds	45,154,392	0.48%

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC rating.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 3,883,313,100	41.34%	3.07	P/RP-1	$ -	0.00%
3.02	NAIC-2	944,329,099	10.05%	3.08	P/RP-2	-	0.00%
3.03	NAIC-3	163,788,850	1.74%	3.09	P/RP-3	-	0.00%
3.04	NAIC-4	19,412,165	0.21%	3.10	P/RP-4	-	0.00%
3.05	NAIC-5	-	0.00%	3.11	P/RP-5	-	0.00%
3.06	NAIC-6	222,629	0.00%	3.12	P/RP-6	-	0.00%

4. Assets held in foreign investments:

4.01	Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets?		Yes [ ]	No [X]
4.02	Total admitted assets held in foreign investments.	$	308,962,094	3.29%
4.03	Foreign-currency-denominated investments.		-	0.00%
4.04	Insurance liabilities denominated in that same foreign currency		-	0.00%

If response, to 4.01 above is yes, responses are not required for interrogatories 5 -10.

5. Aggregate foreign investment exposure categorized by NAIC sovereign rating:

			1	2
5.01	Countries rated NAIC - 1	$	308,962,094	3.29%
5.02	Countries rated NAIC - 2		-	0.00%
5.03	Countries rated NAIC - 3 or below		-	0.00%

6. Two largest foreign investment exposures to a single country, categorized by the country's NAIC sovereign rating:

				1	2
	Countries rated NAIC - 1:				
6.01	Country:	Cayman Islands	$	229,061,673	2.44%
6.02	Country:	Switzerland		20,570,000	0.22%
	Countries rated NAIC - 2				
6.03	Country:		$	-	0.00%
6.04	Country:			-	0.00%
	Countries rated NAIC - 3 or below				
6.05	Country:		$	-	0.00%
6.06	Country:			-	0.00%

7. Aggregate unhedged foreign currency exposure:

	1	2
$	-	0.00%

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign rating:

			1	2
8.01	Countries rated NAIC - 1	$	-	0.00%
8.02	Countries rated NAIC - 2		-	0.00%
8.03	Countries rated NAIC - 3 or below		-	0.00%

9. NAIC sovereign rating:

			1	2
	Countries rated NAIC - 1:			
9.01	Country:	$	-	0.00%
9.02	Country:		-	0.00%
	Countries rated NAIC - 2			
9.03	Country:	$	-	0.00%
9.04	Country:		-	0.00%
	Countries rated NAIC - 3 or below			
9.05	Country:	$	-	0.00%
9.06	Country:		-	0.00%

10. List the 10 largest nonsovereign (i.e. nongovernmental) foreign issues:

	1	2		3	4
	Issuer	**NAIC Rating**			
10.01	Park Avenue Institutional Advisers CLO Ltd 2017-1	1FE	$	18,850,000	0.20%
10.02	Credit Suisse Group AG	2FE		15,840,000	0.17%
10.03	CBAM 2017-1 Ltd.	1FE		14,768,160	0.16%
10.04	Carlyle Global Market Strategies CLO 2014-3-R Ltd	1FE		14,016,402	0.15%
10.05	Neuberger Berman Loan Advisers Clo 26 Ltd.	1FE		13,753,211	0.15%
10.06	Mitsubishi UFJ Financial Group Inc.	1FE		13,534,626	0.14%
10.07	Tiaa Clo III Ltd	1FE		12,880,000	0.14%
10.08	Palmer Square CLO 2018-2 Ltd	1FE		12,674,438	0.13%
10.09	Carlyle US CLO 2017-4 Ltd	1FE		12,500,000	0.13%
10.10	ANZ New Zealand (Int'l) Limited	1FE		11,016,583	0.12%

11. Amounts and percentage of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01	Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 11.01 above is yes, responses are not required for the remainder of interrogatory 11.			
11.02	Total admitted assets held in Canadian Investments	$	-	0.00%
11.03	Canadian-currency-denominated investments		-	0.00%
11.04	Canadian-denominated insurance liabilities		-	0.00%
11.05	Unhedged Canadian currency exposure		-	0.00%

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions.

12.01	Are assets held in investments with contractual sales restrictions less than 2.5 % of the reporting entity's total admitted assets?	Yes [X]	No [ ]	
	If response to 12.01 above is yes, responses are not required for the remainder of interrogatory 12.			
	1		**2**	**3**
12.02	Aggregate statement value of investments with contractual sales restrictions	$	-	0.00%
	Largest 3 investments with contractual sales restrictions			
12.03			-	0.00%
12.04			-	0.00%
12.05			-	0.00%

13. Amounts and percentage of admitted assets held in the largest 10 equity interests:

13.01	Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]
	If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.	

	1 Name of Issuer	2	3
13.02	-	$ -	0.00%
13.03	-	-	0.00%
13.04	-	-	0.00%
13.05	-	-	0.00%
13.06	-	-	0.00%
13.07	-	-	0.00%
13.08	-	-	0.00%
13.09	-	-	0.00%
13.10	-	-	0.00%
13.11	-	-	0.00%

14. Amounts and percentage of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01	Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]
	If response to 14.01 above is yes, responses are not required for 14.02 through 14.05.	

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ -	0.00%
	Largest 3 investments held in nonaffiliated, privately placed equities:		
14.03		-	0.00%
14.04		-	0.00%
14.05		-	0.00%

Ten largest fund managers:

	1 Fund Manager	2 Total Invested	3 Diversified	4 Nondiversified
14.06	JPMorgan Trust II - JPMorgan U.S. Treasury Plus Money Market Fund	$ 255,138,934	$ 255,138,934	$ -
14.07	First American Funds Inc. - Treasury Obligations Fund	188,666,582	188,666,582	-
14.08	JP Morgan	170,013,151	170,013,151	-
14.09	Fidelity Colchester Street Trust - Treasury Portfolio	136,052	136,052	-
14.10	BlackRock Liquidity Funds - Treasury Trust Fund	77,778	77,778	-
14.11	Wells Fargo Funds Trust - Treasury Plus Money Market Fund	55,009	55,009	-
14.12	BlackRock Liquidity Funds - T-Fund	26,882	26,882	-
14.13		-	-	-
14.14		-	-	-
14.15		-	-	-

15. Amounts and percentage of the reporting entity's total admitted assets held in general partnership interests:

15.01	Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets?	Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ -	0.00%
	Largest 3 investments held in general partnership interests:		
15.03		-	0.00%
15.04		-	0.00%
15.05		-	0.00%

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01	Are mortgage loans reported on Schedule B less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of interrogatory 16 and interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$ -	0.00%
16.03		-	0.00%
16.04		-	0.00%
16.05		-	0.00%
16.06		-	0.00%
16.07		-	0.00%
16.08		-	0.00%
16.09		-	0.00%
16.10		-	0.00%
16.11		-	0.00%

Amounts and percentages of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
		1	2
16.12	Construction loans	$ -	0.00%
16.13	Mortgage loans over 90 days past due	-	0.00%
16.14	Mortgage loans in the process of foreclosure	-	0.00%
16.15	Mortgage loans foreclosed	-	0.00%
16.16	Restructured mortgage loans	-	0.00%

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

	Loan-to-Value	Residential		Commercial		Agricultural	
		1	2	3	4	5	6
17.01	above 95%	$ -	0.00%	$ -	0.00%	$ -	0.00%
17.02	91% to 95%	-	0.00%	-	0.00%	-	0.00%
17.03	81% to 90%	-	0.00%	-	0.00%	-	0.00%
17.04	71% to 80%	-	0.00%	-	0.00%	-	0.00%
17.05	below 70%	-	0.00%	-	0.00%	-	0.00%

18. Amounts and percentage of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01	Are assets held in real estate reported in Schedule A less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ -	0.00%
18.03		-	0.00%
18.04		-	0.00%
18.05		-	0.00%
18.06		-	0.00%

19. Report aggregate amounts and percentage of the reporting entity's total admitted assets held in investments held in mezzanine real-estate loans.

19.01	Are assets held in real estate reported in mezzanine real-estate loans less than 2.5% of the reporting entity's total admitted assets?	Yes [X]	No [ ]

If response 19.01 above is yes, responses are not required for the remainder of interrogatory 19.

19.02	Aggregate statement value of investments held in mezzanine real-estate loans:	**2**	**3**
		$ -	0.00%

Largest three investments in any one parcel or group of contiguous parcels of real estate.

	Description **1**	**2**	**3**
19.03	-	$ -	0.00%
19.04	-	-	0.00%
19.05	0	-	0.00%

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year-end		**At End of Each Quarter**		
				1st Qtr	**2nd Qtr**	**3rd Qtr**
		1	**2**	**3**	**4**	**5**
20.01	Securities Lending agreements	$ -	0.00%	$ -	$ -	$ -
20.02	Repurchase agreements	-	0.00%	-	-	-
20.03	Reverse repurchase agreements	-	0.00%	-	-	-
20.04	Dollar repurchase agreements	-	0.00%	-	-	-
20.05	Dollar reverse repurchase agreements	-	0.00%	-	-	-

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
				1st Qtr	2nd Qtr
		1	2	3	4
21.01	Hedging	$ -	0.00%	$ -	0.00%
21.02	Income Generation	-	0.00%	-	0.00%
21.03	Other	-	0.00%	-	0.00%

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
22.01	Hedging	$ -	0.00%	$ -	$ -	$ -
22.02	Income Generation	-	0.00%	-	-	-
22.03	Replications	-	0.00%	-	-	-
22.04	Other	-	0.00%	-	-	-

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year-end		At End of Each Quarter		
				1st Qtr	2nd Qtr	3rd Qtr
		1	2	3	4	5
23.01	Hedging	$ -	0.00%	$ -	$ -	$ -
23.02	Income Generation	-	0.00%	-	-	-
23.03	Replications	-	0.00%	-	-	-
23.04	Other	-	0.00%	-	-	-

Humana Insurance Company
Summary Investment Schedule
Statutory Basis of Accounting
December 31, 2020

		Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement	
		1	2	1	2
		Amount	Percentage	Amount	Percentage
1. Long-Term Bonds					
1.01	U.S. governments	$ 86,450,865	1.36%	$ 86,450,865	1.36%
1.02	All other governments	-	0.00%	-	0.00%
1.03	U.S. states, territories and possessions, etc. guaranteed	40,724,739	0.64%	40,724,739	0.64%
1.04	U.S. political subdivisions of states, territories, and possessions, guaranteed	60,193,948	0.95%	60,193,948	0.95%
1.05	U.S. special revenue and special assessment obligations, etc. non-guaranteed	1,426,364,809	22.49%	1,426,364,809	22.49%
1.06	Industrial and miscellaneous	2,493,333,034	39.30%	2,493,333,034	39.30%
1.07	Hybrid securities	-	0.00%	-	0.00%
1.08	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
1.09	SVO identified funds	-	0.00%	-	0.00%
1.10	Unaffiliated Bank loans	-	0.00%	-	0.00%
1.11	Total long-term bonds	4,107,067,395	64.74%	4,107,067,395	64.74%
2. Preferred stocks					
2.01	Industrial and miscellaneous (Unaffiliated)	-	0.00%	-	0.00%
2.02	Parent, subsidiaries and affiliates	-	0.00%	-	0.00%
2.03	Total preferred stocks	-	0.00%	-	0.00%
3. Common stocks					
3.01	Industrial and miscellaneous Publicly traded (Unaffiliated)	-	0.00%	-	0.00%
3.02	Industrial and miscellaneous Other (Unaffiliated)	-	0.00%	-	0.00%
3.03	Parent, subsidiaries and affiliates Publicly traded	-	0.00%	-	0.00%
3.04	Parent, subsidiaries and affiliates Other	742,129,787	11.70%	742,129,787	11.70%
3.05	Mutual funds	-	0.00%	-	0.00%
3.06	Unit investment trusts	-	0.00%	-	0.00%
3.07	Closed-end funds	-	0.00%	-	0.00%
3.08	Total common stocks	742,129,787	11.70%	742,129,787	11.70%
4. Mortgage loans					
4.01	Farm mortgages	-	0.00%	-	0.00%
4.02	Residential mortgages	-	0.00%	-	0.00%
4.03	Commercial mortgages	8,550,000	0.13%	8,550,000	0.13%
4.04	Mezzanine real estate loans	-	0.00%	-	0.00%
4.05	Total valuation allowance	-	0.00%	-	0.00%
4.06	Total mortgage loans	8,550,000	0.13%	8,550,000	0.13%
5. Real estate					
5.01	Properties occupied by company	10,899,516	0.17%	10,899,516	0.17%
5.02	Properties held for production of income	-	0.00%	-	0.00%
5.03	Properties held for sale	-	0.00%	-	0.00%
5.04	Total real estate	10,899,516	0.17%	10,899,516	0.17%
6. Cash, cash equivalents and short-term investments					
6.01	Cash	126,828,448	2.00%	126,828,448	2.00%
6.02	Cash equivalents	1,180,710,045	18.61%	1,180,710,045	18.61%
6.03	Short-term investments	167,389,639	2.64%	167,389,639	2.64%
6.04	Total cash, cash equivalents and short-term investments	1,474,928,132	23.25%	1,474,928,132	23.25%
7. Contract loans		-	0.00%	-	0.00%
8. Derivatives		-	0.00%	-	0.00%
9. Other invested assets		-	0.00%	-	0.00%
10. Receivables for securities		35,000	0.00%	35,000	0.00%
11. Securities Lending		-	0.00%	-	0.00%
12. Other invested assets		-	0.00%	-	0.00%
13.	Total invested assets	$ 6,343,609,830	100.00%	$ 6,343,609,830	100.00%

Attachment I
Humana Bold Goal Report

2021 Bold Goal Progress Report

2020 Results

Whole-person health focus creates positive results

When the COVID-19 crisis created more immediate needs than ever within our communities, we and our partners wasted no time in getting together to problem solve and get needed clinical and social support to members. The latest Bold Goal survey shows these efforts were a worthwhile investment in our members' health.

Report Highlights

2020 survey results show:

Humana Medicare Advantage members maintained overall health-related quality of life in 2020, while experiencing more physically Healthy Days.

Humana conducted nearly 6.2 million screenings for health-related social needs in 2020.

Vulnerable populations – members with depression, on low-income subsidy (LIS), are disabled, or are dual-eligible for Medicare and Medicaid – experienced more Healthy Days.

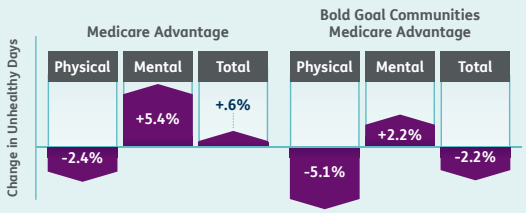
Humana's Basic Needs Program made a direct impact on food insecurity by bridging the gap in access to food due to the pandemic.

Medicare Advantage members maintained their overall health in 2020

Humana measures the health-related quality of life of members through the Centers for Disease Control and Prevention's Healthy Days survey, in which members self-report both their physical and mental health-related quality of life over the previous 30 days. Each year's survey results are compared to baseline year membership population characteristics to track progress. Results show MA members maintained overall health despite the pandemic, with a reduction in physically unhealthy days.

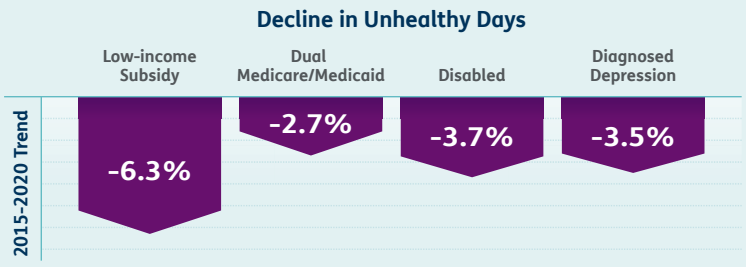
Healthy Days Survey from Baseline Year 2015 - 2020

Both Humana overall Medicare Advantage membership and those in Bold Goal communities saw decreases in physically unhealthy days from baseline year 2015, with MA members in BG communities experiencing fewer unhealthy days overall. Mentally unhealthy days increases are likely driven by pandemic-related year-over-year effects.



Improved Healthy Days for Vulnerable Individuals

Notably, some of those most impacted by the pandemic experienced an overall decline in unhealthy days partly due to efforts connecting them to needed resources.



Humana

GCHL7YREN 05/2021

To learn more about our Bold Goal progress, visit: populationhealth.humana.com/2021-bold-goal-progress-report

2021 Bold Goal Progress Report

2020 Results

Continued

High-Priority Social Needs

Screenings focus on health-related social needs — barriers to health and quality of life, including food insecurity, loneliness, housing insecurity, financial strain, and transportation barriers.

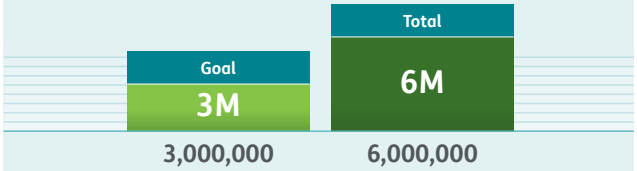
Expanded screening for social needs

In the last two years, we've greatly expanded screening of our members for a comprehensive set of social needs that impact health and quality of life.

In 2020, we set an enterprise wide goal to conduct 3 million screenings.

2020 Screenings

Our advances in screening work continued in 2020. In the end, we more than doubled our goal for social need screenings. Overall, we tracked 6,157,340 screening events.



1.1 Million Meals

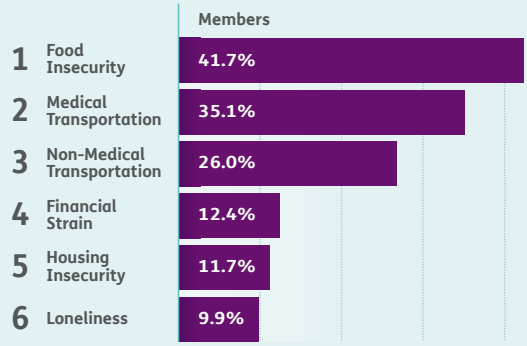
Humana's Basic Needs Program made a direct impact on food insecurity, providing more than 1.1 million meals to at-risk members.

Identified and met social needs

Humana is capturing and measuring data in a new way that allows us to close the loop on social need referrals and continue to follow up as needed – to see that the resource offered helped the member. For example, from December 11, 2020 to March 15, 2021, we measured the gap closure rate of the six social need domains below for a subset of Medicare Advantage members. While some pandemic-driven needs such as access to food and transportation were more immediately resolved, many needs are preexisting and will require more time and resources to address.

Percentage of Met Needs

Truly solving for social needs requires long-term, repeated outreach to connect members to community resources, access to member plan benefits, and care plans for managing complex needs. Through this continued work, we are learning the type and number of interventions needed.



WILLIAM SHRANK, MD
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Bold Goal continues to guide Humana's strategy to address social needs –

and to improve the health of the people and communities we serve by making it easier for everyone to achieve their best health.

Humana.

GCHL7YREN 05/2021

To learn more about our Bold Goal progress, visit:
populationhealth.humana.com/2021-bold-goal-progress-report