

Glossary of Terms

Administrative Services Only (ASO) – An arrangement between an employer or benefit trust and an insurance company, or third party administrator (TPA) where the insurance company or TPA does not assume risk, but performs only specifically contracted services, (e.g., claims processing, and/or utilization management), generally for pre-set administrative fees.

Basis Point (bp) – one basis point equals 1/100th of one percent (e.g. an increase of 85.6% to 85.8% = 20 bp increase)

Cancel Rate – The rate at which orders to buy or sell are canceled before being executed.

Capital Expenditure (Capex) – Amount used during a particular period to acquire or improve long-term assets such as property, plant or equipment.

Capitation – A method of paying medical providers involving a pre-established amount for each covered person. The payment covers all specified services received by the covered person, regardless of the volume of services received by covered persons or the costs incurred by a provider in furnishing those services. The pre-paid amount frequently is adjusted to reflect the demographic characteristics (age/sex) of the members served by the provider(s).

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. This agency administers the Medicare program and works in partnership with the states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), health insurance portability standards, and other programs. In addition to these programs, CMS has other responsibilities, including administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in health care facilities through its survey and certification activity, and clinical laboratory quality standards.

Certificates of Coverage – The contract setting forth the benefits to which covered persons are entitled under their health benefit policy, including any conditions to receipt of and exclusions from their coverage.

Coinsurance – A percentage of health care costs for which the member is responsible under the member's health benefit policy. For example, a member might pay for 20 percent of the cost of a service, with the health coverage policy paying the remaining cost.

Consumerism – In the health insurance industry, a focus on involving the covered member more directly in the selection of services, based on their price and quality.

Copayment – A fixed amount of health care costs for which the member is responsible under the member's health benefit policy. For example, a member might pay \$15 for each visit to a physician, with the health coverage policy paying the remaining cost.

Days in Claims Payable (DCP) – Incurred But Not Reported (IBNR) medical claims liabilities at the end of the period divided by average medical claims expenses per day in the period.

Deductible – The portion of the covered member's health care expenses that must be paid out of pocket before the member's plan begins paying its share.

Department of Insurance (DOI) – State agencies that regulate insurers.

Exchange Communication Network (ECN) – High-speed, automated trading platforms that match buyers and sellers directly.

Exchange-Traded Fund (ETF) – A portfolio of stocks that mirrors the composition of a market index. ETFs trade like stocks

Explanation of Benefits (EOB) – A summary of the payments made by an insurer or health plan on behalf of an insured to a health care provider and any appeal rights the insured may have.

Fee-for-Service (FFS) – Payment of specific amounts for specific services rendered on a service unit basis.

Flexible Spending Account (FSA) – Also known as Unreimbursed Medical and Dependent Care Spending Accounts, these accounts are a tax-advantaged way to pay for out-of-pocket healthcare expenses, and work-related daycare expenses. This benefit allows an individual to pay for eligible expenses with "pre-tax" dollars, which means that he or she gets an exclusion from income for these expenses before ever filing a tax return. The individual doesn't pay federal income or Social Security taxes on this money and, in most states, will not pay state taxes either. Authorized by the IRS, these accounts let the individual set aside money from his or her salary before taxes are withheld. As they incur healthcare expenses or daycare expenses throughout the year, they submit a claim for those expenses, and are reimbursed with tax-free dollars from their account(s). Any unspent balance is forfeited at the end of the grace period (or within 3 months in the next year, under new rulings), it is not portable from one employer to another employer should the employee change employers during the plan period, and the account does not earn investment income.

Form 10-K – SEC report that a publicly-traded company must file with the SEC on an annual basis. It provides a comprehensive overview of the company's business and financial condition. Form 10-K must be filed with the SEC within 60 days after the end of the company's fiscal year.

Form 10-Q -- SEC report that a publicly-traded company must file with the SEC on a quarterly basis. It includes unaudited financial statements and provides an updated view of the company's results and financial position since the filing of the last Form 10-K. The report must be filed for each of the first three fiscal quarters of the company's fiscal year and is due within 40 days of the close of the quarter.

Form 8-K – SEC “current report” used to report certain events or provide additional information that has previously not been reported by the company in a quarterly report (Form 10-Q) or annual report (Form 10-K). An example of these events or changes would be an acquisition or sale of significant assets not made in the ordinary course of the company's business.

Generally Accepted Accounting Principles (GAAP) – The overall conventions, rules, and procedures that define accepted accounting practice at a particular time in the U.S. A combination of promulgations by accounting governance bodies, the SEC, and industry practice within a particular sector.

Health Insurance Portability and Accountability Act (HIPAA) – A federal law enacted in 1996 with many provisions that established national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. It also contains provisions designed to make it easier for individuals to avoid lapses in health coverage when transferring from one employer to another.

Health Maintenance Organizations (HMO) -- A type of coordinated care plan involving a network of providers from whom members receive all health care (other than emergency care while traveling outside of the network area.) An HMO typically involves selection of a primary care physician who coordinates all care, including services of providers such as specialists and hospitals.

Health Reimbursement Arrangement (HRA) – Similar to that of an FSA, except that, contributions are made by the employer only and the unspent balance is usually able to be carried over to the next plan period depending on the plan. Generally, HRA balances are not portable and are forfeited upon leaving an employer.

Health Savings Account (HSA) – Somewhat similar to that of an HRA with three primary advantages. First, participants may always carry-over any unspent balances indefinitely. Second, the participant owns the amounts in the account, so that no funds are lost if the participant changes employment. Third, the account may earn investment income. However, unlike HRAs and FSAs, only individuals covered by a high deductible health plan are eligible to have an HSA.

HumanaOne – Humana's health insurance product for the individual market.

Hybrid Market – Both the NYSE and Amex are designing hybrid markets that accommodate orders routed to specialists and to electronic markets, depending on investor preference.

Incurred But Not Reported (IBNR) – Claims that have been incurred by the member, but which have not yet been reported to the insurer.

Indemnity Insurance – A type of health plan product which reimburses for covered health care services received from any health care provider selected by the member. Coverage may be subject to deductibles and coinsurance, with member cost sharing generally limited by out-of-pocket maximums.

INET – An electronic communication network that Nasdaq acquired in December 2005 and on which it is basing its central automated trading platform.

Issuer – A publicly traded firm.

Liquidity – The ability of a trading platform to trade even a large amount of shares without large price swings, due to significant trading interest.

Market Capitalization – A company's market value calculated by multiplying the price of the company's stock by the number of shares outstanding.

Medical Care Ratio (MCR) – See Medical Expense Ratio.

Medical Cost Trend – The change in per member medical costs for the current period compared to the same period in the prior year

Medical Expense Ratio (MER) -- Medical expenses divided by premiums for the same period.

Medical Loss Ratio (MLR) – See Medical Expense Ratio

Medicare – A social insurance program enacted in 1965 that is financed by a combination of payroll taxes from workers and their employers, beneficiary premium payments, and general federal revenues. The program provides health coverage for people age 65 and over, those who have permanent kidney failure requiring dialysis or transplant, and certain individuals under 65 with disabilities.

Medicare Advantage -- A Medicare program that gives beneficiaries the opportunity to select private health plans to provide their Medicare coverage. The private health plans often provide greater benefits than are available under traditional Medicare coverage, but limit the members' choices among providers. Where the program is offered, it is generally available to everyone who has Medicare Part A and is enrolled in B, except those who have End-Stage Renal Disease (unless certain exceptions apply). This program was previously known as Medicare+Choice.

Medicare Modernization Act (MMA) – The recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003 which made the most significant changes to the Medicare program since its passage in 1965. The law provides more choices in health care coverage and adds prescription drug coverage to the program for the first time. MMA created a discount drug card until a new Part D outpatient prescription drug benefit began operation in 2006. The Act allows for competition among health plans to foster innovation and flexibility in coverage, covers new preventive benefits, and makes numerous other changes. (For a more complete discussion, see the MMA page on the CMS website at www.cms.gov .)

Message – An electronic offer to buy or sell a security.

Over the Counter (OTC) Drugs – Drugs that can be purchased without a prescription.

Per Member Per Month (PMPM) – A measure of the average amount of revenue or expense incurred for each member in one month.

Pharmacy Benefits Manager (PBM) – An organization that may assist health plans in various administrative aspects of providing drug coverage, including generally claims payment.

Plan Sponsor – A group (typically an employer) that sponsors the group health plan and is generally responsible for contracting for the various service providers for the plans, including, for example, insurance companies and TPAs.

Preferred Provider Organization (PPO) – Coordinated care arrangement involving a group of hospitals, physicians, and other providers who have contracts with an insurer, employer, third-party administrator, or other sponsoring group to provide health care services to covered persons. Under a PPO health plan, covered persons generally pay less when they use the providers in the PPO network than when using non-network providers.

Premium Yield – The change in per member premiums (after benefit buy-downs) for the current period compared to the same period in the prior year.

Prescription Drug Plan (PDP) -- Prescription drug coverage, typically used to refer to Part D of the Medicare Modernization Act for Medicare eligibles.

Prior Period Development (PPD) – The change in estimated claims expense based on more updated information as IBNR claims become reported claims.

Prospective Payment System (PPS) – Any method of paying hospitals or other health care providers for a defined period or episode of care according to amounts or rates of payment established in advance.

Regulation Fair Disclosure (Reg FD) – SEC regulation that aims to promote the full and fair disclosure of material information to investors. Reg FD provides that issuers are not to disclose material nonpublic information to certain individuals or entities – generally, securities market professionals, such as stock analysts, or holders of the issuer’s securities – that is not publicly available. Should the issuer inadvertently do so, the issuer must make immediate public disclosure of such information.

Regulation National Market System (Reg NMS) – Adopted by the SEC in April 2005, it expands the number of stocks that are covered by the trade-through rule and ensures that trades will be sent to the trading platform that offers the best price.

Required Surplus – This is an amount governed by each state where a regulated insurance company is licensed. It equals the minimum level of capital and surplus (statutory equity) required to demonstrate sufficient financial solvency. Often the RBC calculation governs this requirement.

Risk Based Capital (RBC) Calculation – An algorithm developed and maintained by the National Association of Insurance Commissioners to calculate the required level of minimum capital and surplus (statutory equity) required to demonstrate sufficient financial solvency. For a given entity, the RBC calculation quantifies the level of risk and the required level of statutory equity to cover the uncertainties of 1) credit risk, 2) asset risk, 3) underwriting risk, and 4) business risk.

Sarbanes-Oxley Act (SOX) – Legislation enacted July 2002 that redesigned federal regulation of financial reporting and governance of publicly-held companies. It significantly tightens accountability standards for CEOs, CFOs, boards of directors, auditors and others. There are two sections that which appear to have been receiving the most attention from investors: (1) Section 302 requires CEOs and CFOs to sign statements under penalty of perjury, verifying the completeness and accuracy of company financial statements, and (2) Section 404 requires CEOs, CFOs and outside auditors to attest to the effectiveness of internal controls for financial reporting.

Securities and Exchange Commission (SEC) – A federal agency that regulates the U.S. securities markets. The SEC also oversees the securities industry and promotes disclosure of material information to the investing public.

Selling, General, and Administrative expenses (SG&A) – Expenses such as employees' salaries and related benefits, commissions, marketing and advertising, rent, insurance, and premium taxes.

SG&A Expense Ratio – SG&A expenses (excluding depreciation and amortization) divided by the sum of premiums plus ASO fees.

SmartExpress – Humana’s latest entry of health insurance products and services designed especially for small business with 2 to 299 employees. SmartExpress benefits

employers, who can better predict and manage annual health care costs, and employees, who have a broader choice of insurance coverage options under the new plan.

SmartSuite – Humana’s consumer-choice health benefits solution. It gives more cost control and predictability for both the short and long-term to employers, and more choice and control over health care decision-making to employees. SmartSuite consists of nine bundles of health plans, each containing 4-6 plans, including HMOs, PPOs, and CoverageFirst, a PPO plan with an upfront benefit allowance.

Spread – The difference between what people are willing to pay for a stock and what sellers are willing to sell it for. Markets with narrow spreads are considered more efficient than markets with wide spreads.

Statutory Accounting – A separate basis of accounting required by the National Association of Insurance Commissioners (NAIC), which focuses on the solvency of state regulated insurance companies.

Stop-loss – A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. This may apply to an entire health plan or to any single component.

Subrogation – A health benefits company may reserve the “right of subrogation” in the event of a loss. This means that the company may recover the amount of benefits paid by the company for injuries to an insured individual in a case in which the insured individual is subsequently reimbursed for the injury by a third party whose conduct was alleged to have caused it.

Summary Plan Description – A summary of the benefits available under an employee’s health benefits plan.

Trade-Through Rule – An SEC rule that requires stock markets to send trades to other trading platforms where a better price is available. A trade-through transaction is one that does not occur at the best available price in a market.

Trading Platform – A general term that includes stock markets, stock exchanges and electronic communication networks.

TRICARE – Medical coverage program sponsored by the Department of Defense (DoD). The DoD contracts with select health insurers to be the sole providers of health benefits coverage in defined regions of the country on an insured basis to the beneficiaries of the military and military retirees and on an ASO basis for active duty military personnel.

Unlisted Trade Privilege (UTP) – The right of a trading platform to trade a stock that is listed on another market or exchange.